

As Introduced

**127th General Assembly
Regular Session
2007-2008**

H. B. No. 179

Representative Blessing

—

A BILL

To amend sections 126.30, 1751.55, 1751.60, 3923.05, 1
3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 2
4121.01, 4121.44, 4121.441, 4121.442, 4123.01, 3
4123.30, 4123.343, 4123.35, 4123.511, 4123.512, 4
4123.82, and 4123.93 and to enact section 4123.513 5
of the Revised Code to require a health insurer 6
and allow an employee, during the time an 7
employee's workers' compensation claim is pending 8
approval, to pay for services provided to care for 9
an employee's workplace injury or occupational 10
disease and to require the Administrator of 11
Workers' Compensation or a self-insuring employer, 12
as appropriate, to reimburse that health insurer 13
or employee for expenses they paid for a claim 14
once it is deemed compensable. 15

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 126.30, 1751.55, 1751.60, 3923.05, 16
3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 4121.01, 4121.44, 17
4121.441, 4121.442, 4123.01, 4123.30, 4123.343, 4123.35, 4123.511, 18
4123.512, 4123.82, and 4123.93 be amended and section 4123.513 of 19
the Revised Code be enacted to read as follows: 20

Sec. 126.30. (A) Any state agency that purchases, leases, or 21
otherwise acquires any equipment, materials, goods, supplies, or 22
services from any person and fails to make payment for the 23
equipment, materials, goods, supplies, or services by the required 24
payment date shall pay an interest charge to the person in 25
accordance with division (E) of this section, unless the amount of 26
the interest charge is less than ten dollars. Except as otherwise 27
provided in division (B), (C), or (D) of this section, the 28
required payment date shall be the date on which payment is due 29
under the terms of a written agreement between the state agency 30
and the person or, if a specific payment date is not established 31
by such a written agreement, the required payment date shall be 32
thirty days after the state agency receives a proper invoice for 33
the amount of the payment due. 34

(B) If the invoice submitted to the state agency contains a 35
defect or impropriety, the agency shall send written notification 36
to the person within fifteen days after receipt of the invoice. 37
The notice shall contain a description of the defect or 38
impropriety and any additional information necessary to correct 39
the defect or impropriety. If the agency sends such written 40
notification to the person, the required payment date shall be 41
thirty days after the state agency receives a proper invoice. 42

(C) In applying this section to claims submitted to the 43
department of job and family services by providers of equipment, 44
materials, goods, supplies, or services, the required payment date 45
shall be the date on which payment is due under the terms of a 46
written agreement between the department and the provider. If a 47
specific payment date is not established by a written agreement, 48
the required payment date shall be thirty days after the 49
department receives a proper claim. If the department determines 50
that the claim is improperly executed or that additional evidence 51
of the validity of the claim is required, the department shall 52

notify the claimant in writing or by telephone within fifteen days 53
after receipt of the claim. The notice shall state that the claim 54
is improperly executed and needs correction or that additional 55
information is necessary to establish the validity of the claim. 56
If the department makes such notification to the provider, the 57
required payment date shall be thirty days after the department 58
receives the corrected claim or such additional information as may 59
be necessary to establish the validity of the claim. 60

(D) In applying this section to invoices submitted to the 61
~~bureau~~ administrator of workers' compensation for equipment, 62
materials, goods, supplies, or services provided to employees in 63
connection with an employee's claim against the state insurance 64
fund, the public work-relief employees' compensation fund, the 65
coal-workers pneumoconiosis fund, or the marine industry fund as 66
compensation for injuries or occupational disease pursuant to 67
Chapter 4123., 4127., or 4131. of the Revised Code, the required 68
payment date shall be the date on which payment is due under the 69
terms of a written agreement between the ~~bureau~~ administrator and 70
the health care provider. If a specific payment date is not 71
established by a written agreement entered into between the 72
administrator and the health care provider, or if a health insurer 73
or an employee submits the invoice to the administrator pursuant 74
to section 4123.513 of the Revised Code, the required payment date 75
shall be thirty days after the ~~bureau~~ administrator receives a 76
proper invoice for the amount of the payment due or thirty days 77
after the final adjudication allowing payment of an award to the 78
employee, whichever is later. Nothing in this section shall 79
supersede any faster timetable for payments to health care 80
providers contained in sections 4121.44 and 4123.512 of the 81
Revised Code. 82

For purposes of this division, a "proper invoice" includes 83
the claimant's name, claim number and date of injury, employer's 84

name, the health care provider's name and address, the health care 85
provider's assigned payee number, a description of the equipment, 86
materials, goods, supplies, or services provided by the provider 87
to the claimant, the date provided, and the amount of the charge. 88
If more than one item of equipment, materials, goods, supplies, or 89
services is listed by a health care provider on a single 90
application for payment, each item shall be considered separately 91
in determining if it is a proper invoice. 92

If prior to a final adjudication the ~~bureau~~ administrator 93
determines that the invoice contains a defect, the ~~bureau~~ 94
administrator shall notify the health care provider in writing at 95
least fifteen days prior to what would be the required payment 96
date if the invoice did not contain a defect. The notice shall 97
contain a description of the defect and any additional information 98
necessary to correct the defect. If the bureau sends a 99
notification to the provider, the required payment date shall be 100
redetermined in accordance with this division after the bureau 101
receives a proper invoice. If after a final adjudication a health 102
insurer or employee submits a copy of an invoice to the 103
administrator under section 4123.513 of the Revised Code and the 104
administrator determines that the invoice contains a defect, the 105
administrator shall notify the health insurer or employee in 106
writing at least fifteen days prior to what would be the required 107
payment date if the invoice did not contain a defect. The notice 108
shall contain a description of the defect and any additional 109
information necessary to correct the defect. If the administrator 110
sends a notification to the health insurer or employee, the 111
required payment date shall be redetermined in accordance with 112
this division after the administrator receives a proper invoice. 113

For purposes of this division, ~~"final:~~ 114

(1) "Health insurer" has the same meaning as in section 115
4121.01 of the Revised Code. 116

(2) "Final adjudication" means the later of the date of the 117
decision or other action by the ~~bureau~~ administrator, the 118
industrial commission, or a court allowing payment of the award to 119
the employee from which there is no further right to 120
reconsideration or appeal that would require the ~~bureau~~ 121
administrator to withhold compensation and benefits, or the date 122
on which the rights to reconsideration or appeal have expired 123
without an application therefor having been filed or, if later, 124
the date on which an application for reconsideration or appeal is 125
withdrawn. If after final adjudication, the administrator ~~of the~~ 126
~~bureau of workers' compensation~~ or the industrial commission makes 127
a modification with respect to former findings or orders, pursuant 128
to Chapter 4123., 4127., or 4131. of the Revised Code or pursuant 129
to court order, the adjudication process shall no longer be 130
considered final for purposes of determining the required payment 131
date for invoices for equipment, materials, goods, supplies, or 132
services provided after the date of the modification when the 133
propriety of the invoices is affected by the modification. 134

(E) The interest charge on amounts due shall be paid to the 135
person for the period beginning on the day after the required 136
payment date and ending on the day that payment of the amount due 137
is made. The amount of the interest charge that remains unpaid at 138
the end of any thirty-day period after the required payment date, 139
including amounts under ten dollars, shall be added to the 140
principal amount of the debt and thereafter the interest charge 141
shall accrue on the principal amount of the debt plus the added 142
interest charge. The interest charge shall be at the rate per 143
calendar month that equals one-twelfth of the rate per annum 144
prescribed by section 5703.47 of the Revised Code for the calendar 145
year that includes the month for which the interest charge 146
accrues. 147

(F) No appropriations shall be made for the payment of any 148

interest charges required by this section. Any state agency 149
required to pay interest charges under this section shall make the 150
payments from moneys available for the administration of agency 151
programs. 152

If a state agency pays interest charges under this section, 153
but determines that all or part of the interest charges should 154
have been paid by another state agency, the state agency that paid 155
the interest charges may request the attorney general to determine 156
the amount of the interest charges that each state agency should 157
have paid under this section. If the attorney general determines 158
that the state agency that paid the interest charges should have 159
paid none or only a part of the interest charges, the attorney 160
general shall notify the state agency that paid the interest 161
charges, any other state agency that should have paid all or part 162
of the interest charges, and the director of budget and management 163
of the attorney general's decision, stating the amount of interest 164
charges that each state agency should have paid. The director 165
shall transfer from the appropriate funds of any other state 166
agency that should have paid all or part of the interest charges 167
to the appropriate funds of the state agency that paid the 168
interest charges an amount necessary to implement the attorney 169
general's decision. 170

(G) Not later than forty-five days after the end of each 171
fiscal year, each state agency shall file with the director of 172
budget and management a detailed report concerning the interest 173
charges the agency paid under this section during the previous 174
fiscal year. The report shall include the number, amounts, and 175
frequency of interest charges the agency incurred during the 176
previous fiscal year and the reasons why the interest charges were 177
not avoided by payment prior to the required payment date. The 178
director shall compile a summary of all the reports submitted 179
under this division and shall submit a copy of the summary to the 180

president and minority leader of the senate and to the speaker and 181
minority leader of the house of representatives no later than the 182
thirtieth day of September of each year. 183

Sec. 1751.55. A health insuring corporation policy, contract, 184
or agreement shall not be construed to exclude an illness or an 185
injury upon the ground that the subscriber might have elected to 186
have such illness or injury covered by workers' compensation under 187
Chapter 4121., 4123., 4127., or 4131. of the Revised Code unless 188
the policy, contract, or agreement clearly excludes work or 189
occupational related illness or injury, or the policy, contract, 190
or agreement, or a separate writing signed by the subscriber, 191
informs the subscriber that such coverage is excluded and may be 192
available to the subscriber under workers' compensation as the 193
sole proprietor of a business, a member of a partnership, or an 194
officer of a family farm corporation. Notwithstanding section 195
3901.71 of the Revised Code, a health insuring corporation policy, 196
contract, or agreement shall include coverage for an injury or 197
occupational illness that may be covered under Chapter 4121., 198
4123., 4127., or 4131. of the Revised Code in accordance with 199
section 4123.513 of the Revised Code. 200

Sec. 1751.60. (A) Except as provided for in divisions (E) and 201
(F) of this section, every provider or health care facility that 202
contracts with a health insuring corporation to provide health 203
care services to the health insuring corporation's enrollees or 204
subscribers shall seek compensation for covered services solely 205
from the health insuring corporation and not, under any 206
circumstances, from the enrollees or subscribers, except for 207
approved copayments and deductibles. 208

(B) No subscriber or enrollee of a health insuring 209
corporation is liable to any contracting provider or health care 210
facility for the cost of any covered health care services, if the 211

subscriber or enrollee has acted in accordance with the evidence 212
of coverage. 213

(C) Except as provided for in divisions (E) and (F) of this 214
section, every contract between a health insuring corporation and 215
provider or health care facility shall contain a provision 216
approved by the superintendent of insurance requiring the provider 217
or health care facility to seek compensation solely from the 218
health insuring corporation and not, under any circumstances, from 219
the subscriber or enrollee, except for approved copayments and 220
deductibles. 221

(D) Nothing in this section shall be construed as preventing 222
a provider or health care facility from billing the enrollee or 223
subscriber of a health insuring corporation for noncovered 224
services or from billing the administrator of workers' 225
compensation after a final determination is made pursuant to 226
section 4123.511 or 4123.512 of the Revised Code that the 227
subscriber or enrollee is eligible to receive compensation and 228
benefits under Chapter 4121., 4123., 4127., or 4131. of the 229
Revised Code. 230

As used in this division, "final determination" has the same 231
meaning as in section 4123.513 of the Revised Code. 232

(E) Upon application by a health insuring corporation and a 233
provider or health care facility, the superintendent may waive the 234
requirements of divisions (A) and (C) of this section when, in 235
addition to the reserve requirements contained in section 1751.28 236
of the Revised Code, the health insuring corporation provides 237
sufficient assurances to the superintendent that the provider or 238
health care facility has been provided with financial guarantees. 239
No waiver of the requirements of divisions (A) and (C) of this 240
section is effective as to enrollees or subscribers for whom the 241
health insuring corporation is compensated under a provider 242
agreement or risk contract entered into pursuant to Chapter 5111. 243

or 5115. of the Revised Code. 244

(F) The requirements of divisions (A) to (C) of this section 245
apply only to health care services provided to an enrollee or 246
subscriber prior to the effective date of a termination of a 247
contract between the health insuring corporation and the provider 248
or health care facility. 249

Sec. 3923.05. Except as provided in section 3923.07 of the 250
Revised Code, no policy of sickness and accident insurance 251
delivered, issued for delivery, or used in this state shall 252
contain provisions respecting the matters set forth in this 253
section unless such provisions are in the words in which the same 254
appear in this section. Any such provisions in any such policy 255
shall be preceded by the appropriate caption appearing in this 256
section or, at the option of the insurer, by such appropriate 257
individual or group captions or subcaptions as the superintendent 258
of insurance may approve. 259

(A) A provision as follows: Change of occupation. If the 260
insured be injured or contract sickness after having changed ~~his~~ 261
the insured's occupation to one classified by the insurer as more 262
hazardous than that stated in this policy or while doing for 263
compensation anything pertaining to an occupation so classified, 264
the insurer will pay only such portion of the indemnities provided 265
in this policy as the premium paid would have purchased at the 266
rates and within the limits fixed by the insurer for such more 267
hazardous occupation. If the insured changes ~~his~~ the insured's 268
occupation to one classified by the insurer as less hazardous than 269
that stated in this policy, the insurer, upon receipt of proof of 270
such change of occupation, will reduce the premium rate 271
accordingly, and will return the excess pro rata unearned premium 272
from the date of change of occupation or from the policy 273
anniversary date immediately preceding receipt of such proof, 274

whichever is the more recent. In applying this provision, the 275
classification for occupational risk and the premium rates shall 276
be such as have been last filed by the insurer prior to the 277
occurrence of the loss for which the insurer is liable or prior to 278
the date of proof of change in occupation with the state official 279
having supervision of insurance in the state where the insured 280
resided at the time this policy was issued; but if such filing was 281
not required, then the classification of occupational risk and the 282
premium rates shall be those last made effective by the insurer in 283
such state prior to the occurrence of the loss or prior to the 284
date of proof of change in occupation. 285

(B) A provision as follows: Misstatement of age. If the age 286
of the insured has been misstated, all amounts payable under this 287
policy shall be such as the premium paid would have purchased at 288
the correct age. 289

(C) A provision as follows: 290

(1) Other insurance in this insurer. If an accident or 291
sickness or accident and sickness policy or policies previously 292
issued by the insurer to the insured be in force concurrently 293
herewith, making the aggregate indemnity for in 294
excess of dollars, the excess insurance shall be void 295
and all premiums paid for such excess shall be returned to the 296
insured or to ~~his~~ the insured's estate. 297

The insurer shall insert the type of coverage or coverages in 298
the first blank space in the provision in division (C)(1) of this 299
section and the maximum limit of indemnity or indemnities in the 300
second blank space in the provision in division (C)(1) of this 301
section. 302

(2) In lieu of the foregoing provision in division (C)(1) of 303
this section, a provision as follows: Other insurance in this 304
insurer. Insurance effective at any time on the insured under a 305

like policy or policies in this insurer is limited to the one such 306
policy elected by the insured, ~~his~~ the insured's beneficiary or 307
~~his~~ the insured's estate, as the case may be, and the insurer will 308
return all premiums paid for all other such policies. 309

(D) A provision as follows: Insurance with other insurers. If 310
there be other valid coverage, not with this insurer, providing 311
benefits for the same loss on a provision of service basis or on 312
an expense incurred basis and of which this insurer has not been 313
given written notice prior to the occurrence or commencement of 314
loss, the only liability under any expense incurred coverage of 315
this policy shall be for such proportion of the loss as the amount 316
which would otherwise have been payable hereunder plus the total 317
of the like amounts under all such other valid coverages for the 318
same loss of which this insurer had notice bears to the total like 319
amounts under all valid coverages for such loss, and for the 320
return of such portion of the premiums paid as shall exceed the 321
pro-rata portion for the amount so determined. For the purpose of 322
applying this provision when other coverage is on a provision of 323
service basis, the "like amount" of such other coverage shall be 324
taken as the amount which the services rendered would have cost in 325
the absence of such coverage. 326

If the provision in division (D) of this section is included 327
in a policy of sickness and accident insurance which also contains 328
the provision in division (E) of this section, the insurer shall 329
add to the caption of the provision in division (D) of this 330
section the following: Expense incurred benefits. 331

The insurer may at its option include in the provision in 332
division (D) of this section a definition of "other valid 333
coverage" approved as to form by the superintendent. The 334
definition shall not include compensation paid pursuant to Chapter 335
4121., 4123., 4127., or 4131. of the Revised Code. Such definition 336
shall be limited in subject matter to coverage provided by 337

organizations subject to regulation by insurance law or by 338
insurance authorities of this or any other state of the United 339
States or any province of the Dominion of Canada, and by hospital 340
or medical service organizations, and to any other coverage the 341
inclusion of which may be approved by the superintendent. In the 342
absence of such definition in the provision in division (D) of 343
this section, "other valid coverage" as used in such provision 344
shall not include group insurance, automobile medical payments 345
insurance, coverage provided pursuant to Chapter 4121., 4123., 346
4127., or 4131. of the Revised Code, or coverage provided by 347
hospital or medical service organizations or by union welfare 348
plans or employer or employee benefit organizations. 349

~~For~~ Except as otherwise provided in this division, for the 350
purpose of applying the provision in division (D) of this section 351
with respect to any insured, any amount of benefit provided for 352
such insured pursuant to any compulsory benefit statute, including 353
any federal or any other state's workers' compensation law or any 354
employer's liability statute, whether provided by governmental 355
agency or otherwise, shall ~~in all cases~~ be deemed to be "other 356
valid coverage" of which the insurer has had notice. For purposes 357
of division (D) of this section, benefits paid pursuant to Chapter 358
4121., 4123., 4127., or 4131. of the Revised Code shall not be 359
considered "other valid coverage" of which an insurer has had 360
notice. 361

In applying the provision in division (D) of this section no 362
third party liability coverage shall be included as "other valid 363
coverage." 364

(E) A provision as follows: Insurance with other insurers. If 365
there be other valid coverage, not with this insurer, providing 366
benefits for the same loss on other than an expense incurred basis 367
and of which the insurer has not been given written notice prior 368
to the occurrence or commencement of loss, the only liability for 369

such benefits under this policy shall be for such proportion of 370
the indemnities otherwise provided hereunder for such loss as the 371
like indemnities of which the insurer had notice (including the 372
indemnities under this policy) bear to the total amount of all 373
like indemnities for such loss, and for the return of such portion 374
of the premium paid as shall exceed the pro-rata portion for the 375
indemnities thus determined. 376

If the provision in division (E) of this section is included 377
in a policy of sickness and accident insurance which also contains 378
the provision in division (D) of this section, the insurer shall 379
add to the caption of the provision in division (E) of this 380
section the following: Other benefits. 381

The insurer may at its option include in the provision in 382
division (E) of this section a definition of "other valid 383
coverage" approved as to form by the superintendent. The 384
definition shall not include compensation paid pursuant to Chapter 385
4121., 4123., 4127., or 4131. of the Revised Code. Such definition 386
shall be limited in subject matter to coverage provided by 387
organizations subject to regulation by insurance law or by 388
insurance authorities of this or any other state of the United 389
States or any province of the Dominion of Canada, and to any other 390
coverage the inclusion of which may be approved by the 391
superintendent. In the absence of such definition in the provision 392
in division (E) of this section, "other valid coverage" as used in 393
such provision shall not include group insurance, coverage 394
provided pursuant to Chapter 4121., 4123., 4127., or 4131. of the 395
Revised Code, or benefits provided by union welfare plans or by 396
employer or employee benefit organizations. 397

~~For~~ Except as otherwise provided in this division, for the 398
purpose of applying the provision in division (E) of this section 399
with respect to any insured, any amount of benefit provided for 400
such insured pursuant to any compulsory benefit statute, including 401

any federal or any other state's workers' compensation laws or any 402
employer's liability statute, whether provided by a governmental 403
agency or otherwise, shall ~~in all cases~~ be deemed to be "other 404
valid coverage" of which the insurer has had notice. For purposes 405
of division (E) of this section, benefits paid pursuant to Chapter 406
4121., 4123., 4127., or 4131. of the Revised Code shall not be 407
considered "other valid coverage" of which an insurer has had 408
notice. 409

In applying the provision in division (E) of this section no 410
third party liability coverage shall be included as "other valid 411
coverage." 412

(F) A provision as follows: Relation of earnings to 413
insurance. If the total monthly amount of loss of time benefits 414
promised for the same loss under all valid loss of time coverage 415
upon the insured, whether payable on a weekly or monthly basis, 416
shall exceed the monthly earnings of the insured at the time 417
disability commenced or ~~his~~ the insured's average monthly earnings 418
for the period of two years immediately preceding a disability for 419
which claim is made, whichever is the greater, the insurer will be 420
liable only for such proportionate amount of such benefits under 421
this policy as the amount of such monthly earnings or such average 422
monthly earnings of the insured bears to the total amount of 423
monthly benefits for the same loss under all such coverage upon 424
the insured at the time such disability commences and for the 425
return of such part of the premiums paid during such two years as 426
shall ~~exceed~~ exceed the pro-rata amount of the premiums for the 427
benefits actually paid hereunder; this shall not operate to reduce 428
the total monthly amount of benefits payable under all such 429
coverage upon the insured below the sum of two hundred dollars or 430
the sum of the monthly benefits specified in such coverages, 431
whichever is the lesser, nor shall this operate to reduce benefits 432
other than those payable for loss of time. 433

The provision in division (F) of this section may be placed 434
only in a policy of sickness and accident insurance which the 435
insured has a right to continue in force subject to its terms by 436
the timely payment of premiums until at least age fifty or in a 437
policy of sickness and accident insurance issued after the insured 438
has attained age forty-four and which the insured has the right to 439
continue in force subject to its terms by the timely payment of 440
premiums for at least five years from its date of issue. 441

The insurer may at its option include in the provision in 442
division (F) of this section a definition of "valid loss of time 443
coverage" approved as to form by the superintendent. Such 444
definition shall be limited in subject matter to coverage provided 445
by governmental agencies or by organizations subject to regulation 446
by insurance law or by insurance authorities of this or any other 447
state of the United States or any province of the Dominion of 448
Canada or to any other coverage the inclusion of which may be 449
approved by the superintendent or any combination of such 450
coverages. In the absence of such definition in the provision in 451
division (F) of this section "valid loss of time coverage" as used 452
in such provision shall not include any coverage provided for such 453
insured pursuant to any compulsory benefit statute, including any 454
workers' compensation or employer's liability statute, whether 455
provided by a governmental agency or otherwise, or benefits 456
provided by union welfare plans or by employer or employee benefit 457
organizations. 458

(G) A provision as follows: Unpaid premium. Upon the payment 459
of a claim under this policy, any premium then due and unpaid or 460
covered by any note or written order may be deducted therefrom. 461

(H) A provision as follows: Conformity with state statutes. 462
Any provision of this policy which, on its effective date, is in 463
conflict with the statutes of the state in which the insured 464
resides on such date is hereby amended to conform to the minimum 465

requirements of such statutes. 466

(I) A provision as follows: Illegal occupation. The insurer 467
shall not be liable for any loss to which a contributing cause was 468
the insured's commission of or attempt to commit a felony or to 469
which a contributing cause was the insured's being engaged in an 470
illegal occupation. 471

(J) A provision as follows: Intoxicants and narcotics. The 472
insurer shall not be liable for any loss sustained or contracted 473
in consequence of the insured's being intoxicated or under the 474
influence of any narcotic unless administered on the advice of a 475
physician. 476

Sec. 3923.36. No sickness and accident insurance policy shall 477
be construed to exclude an illness or an injury upon the ground 478
that the insured might have elected to have such illness or injury 479
~~covered by workers' compensation under division (A)(3) of section~~ 480
~~4123.01 of the Revised Code unless the policy clearly excludes~~ 481
~~work or occupational related illness or injury or the policy, or a~~ 482
~~separate writing signed by the insured, informs the insured that~~ 483
~~such coverage is excluded and may be available to the subscriber~~ 484
~~under workers' compensation as the sole proprietor of a business,~~ 485
~~a member of a partnership, or an officer of a family farm~~ 486
~~corporation Chapter 4121., 4123., 4127., or 4131. of the Revised~~ 487
Code. Notwithstanding section 3901.71 of the Revised Code, a 488
sickness and accident insurance policy shall include coverage for 489
an injury or occupational illness that may be covered under 490
Chapter 4121., 4123., 4127., or 4131. of the Revised Code in 491
accordance with section 4123.513 of the Revised Code. 492

Sec. 3923.65. (A) As used in this section: 493

(1) "Emergency medical condition" means a medical condition 494
that manifests itself by such acute symptoms of sufficient 495

severity, including severe pain, that a prudent layperson with 496
average knowledge of health and medicine could reasonably expect 497
the absence of immediate medical attention to result in any of the 498
following: 499

(a) Placing the health of the individual or, with respect to 500
a pregnant woman, the health of the woman or her unborn child, in 501
serious jeopardy; 502

(b) Serious impairment to bodily functions; 503

(c) Serious dysfunction of any bodily organ or part. 504

(2) "Emergency services" means the following: 505

(a) A medical screening examination, as required by federal 506
law, that is within the capability of the emergency department of 507
a hospital, including ancillary services routinely available to 508
the emergency department, to evaluate an emergency medical 509
condition; 510

(b) Such further medical examination and treatment that are 511
required by federal law to stabilize an emergency medical 512
condition and are within the capabilities of the staff and 513
facilities available at the hospital, including any trauma and 514
burn center of the hospital. 515

(B) Every individual or group policy of sickness and accident 516
insurance that provides hospital, surgical, or medical expense 517
coverage shall cover emergency services without regard to the day 518
or time the emergency services are rendered or to whether the 519
policyholder, the hospital's emergency department where the 520
services are rendered, or an emergency physician treating the 521
policyholder, obtained prior authorization for the emergency 522
services. 523

(C) Every individual policy or certificate furnished by an 524
insurer in connection with any sickness and accident insurance 525

policy shall provide information regarding the following:	526
(1) The scope of coverage for emergency services;	527
(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;	528 529 530
(3) Any copayments for emergency services.	531
(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of <u>federal or another state's</u> workers' compensation or similar law; automobile medical payment insurance; or, <u>except for coverage provided under Chapter 4121., 4123., 4127., or 4131. of the Revised Code,</u> insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.	532 533 534 535 536 537 538 539 540 541 542 543 544 545
Sec. 3923.66. (A) As used in sections 3923.66 to 3923.70 of the Revised Code:	546 547
(1) "Clinical peer" and "physician" have the same meanings as in section 1751.77 of the Revised Code.	548 549
(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of an insured with respect to health care decisions.	550 551 552
(B) Sections 3923.66 to 3923.70 of the Revised Code do not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability	553 554 555

income, long-term care, hospital indemnity, medicare supplement, 556
medicare, tricare, specified disease, or vision care; coverage 557
issued as a supplement to liability insurance; insurance arising 558
out of federal or another state's workers' compensation or similar 559
law; automobile medical payment insurance; or, except for coverage 560
provided under Chapter 4121., 4123., 4127., or 4131. of the 561
Revised Code, insurance under which benefits are payable with or 562
without regard to fault and which is statutorily required to be 563
contained in any liability insurance policy or equivalent 564
self-insurance. 565

(C) The superintendent of insurance shall establish and 566
maintain a system for receiving and reviewing requests for review 567
from insureds who have been denied coverage of a health care 568
service on the grounds that the service is not a service covered 569
under the terms of the insured's policy or certificate. 570

On receipt of a written request from an insured or authorized 571
person, the superintendent shall consider whether the health care 572
service is a service covered under the terms of the insured's 573
policy or certificate, except that the superintendent shall not 574
conduct a review under this section unless the insured has 575
exhausted the insurer's internal review process. The insurer and 576
the insured or authorized person shall provide the superintendent 577
with any information required by the superintendent that is in 578
their possession and is germane to the review. 579

Unless the superintendent is not able to do so because making 580
the determination requires resolution of a medical issue, the 581
superintendent shall determine whether the health care service at 582
issue is a service covered under the terms of the insured's policy 583
or certificate. The superintendent shall notify the insured and 584
the insurer of its determination or that it is not able to make a 585
determination because the determination requires the resolution of 586
a medical issue. 587

If the superintendent notifies the insurer that making the 588
determination requires the resolution of a medical issue, the 589
insurer shall afford the insured an opportunity for external 590
review under section 3923.67 or 3923.68 of the Revised Code. If 591
the superintendent notifies the insurer that the health care 592
service is not a covered service, the insurer is not required to 593
cover the service or afford the insured an external review. 594

Sec. 3923.75. (A) As used in sections 3923.75 to 3923.79 of 595
the Revised Code: 596

(1) "Clinical peer" and "physician" have the same meanings as 597
in section 1751.77 of the Revised Code. 598

(2) "Authorized person" means a parent, guardian, or other 599
person authorized to act on behalf of a plan member with respect 600
to health care decisions. 601

(B) Sections 3923.75 to 3923.79 of the Revised Code do not 602
apply to any public employee benefit plan covering only accident, 603
credit, dental, disability income, long-term care, hospital 604
indemnity, medicare supplement, medicare, tricare, specified 605
disease, or vision care; coverage issued as a supplement to 606
liability insurance; insurance arising out of federal or another 607
state's workers' compensation or similar law; automobile medical 608
payment insurance; or, except for coverage provided under Chapter 609
4121., 4123., 4127., or 4131. of the Revised Code, insurance under 610
which benefits are payable with or without regard to fault and 611
which is statutorily required to be contained in any liability 612
insurance policy or equivalent self-insurance. 613

(C) The superintendent of insurance shall establish and 614
maintain a system for receiving and reviewing requests for review 615
from plan members who have been denied coverage of a health care 616
service on the grounds that the service is not a service covered 617
under the terms of the public employee benefit plan. 618

On receipt of a written request from a plan member or 619
authorized person, the superintendent shall consider whether the 620
health care service is a service covered under the terms of the 621
plan, except that the superintendent shall not conduct a review 622
under this section unless the plan member has exhausted the plan's 623
internal review process. The plan and the plan member or 624
authorized person shall provide the superintendent with any 625
information required by the superintendent that is in their 626
possession and is germane to the review. 627

Unless the superintendent is not able to do so because making 628
the determination requires resolution of a medical issue, the 629
superintendent shall determine whether the health care service at 630
issue is a service covered under the terms of the plan. The 631
superintendent shall notify the plan member and the plan of its 632
determination or that it is not able to make a determination 633
because the determination requires the resolution of a medical 634
issue. 635

If the superintendent notifies the plan that making the 636
determination requires the resolution of a medical issue, the plan 637
shall afford the plan member an opportunity for external review 638
under section 3923.76 or 3923.77 of the Revised Code. If the 639
superintendent notifies the plan that the health care service is 640
not a covered service, the plan is not required to cover the 641
service or afford the plan member an external review. 642

Sec. 3924.61. As used in sections 3924.61 to 3924.74 of the 643
Revised Code: 644

(A) "Account holder" means the natural person who opens a 645
medical savings account or on whose behalf a medical savings 646
account is opened. 647

(B) "Eligible medical expense" means any expense for a 648
service rendered by a licensed health care provider or a Christian 649

Science practitioner, or for an article, device, or drug 650
prescribed by a licensed health care provider or provided by a 651
Christian Science practitioner, when intended for use in the 652
mitigation, treatment, or prevention of disease; any amount paid 653
for transportation to the location at which such a service is 654
rendered; any amount paid for lodging necessitated by the receipt 655
of care at a nonlocal hospital; or premiums paid for comprehensive 656
sickness and accident insurance, coverage under a health care plan 657
of a health insuring corporation organized under Chapter 1751. of 658
the Revised Code, long-term care insurance as defined in section 659
3923.41 of the Revised Code, medicare supplemental coverage as 660
defined in section 3923.33 of the Revised Code, payments made 661
pursuant to section 4123.513 of the Revised Code that may be 662
subsequently reimbursed by the administrator of workers' 663
compensation or a self-insuring employer under that section, or 664
payments made pursuant to cost sharing agreements under 665
comprehensive sickness and accident plans. An "eligible medical 666
expense" does not include expenses otherwise paid or reimbursed, 667
including medical expenses paid or reimbursed under an automobile 668
or motor vehicle insurance policy, a workers' compensation 669
insurance policy or plan administered by the federal government or 670
another state, or an employer-sponsored health coverage policy, 671
plan, or contract. 672

(C) "Dependent" has the same meaning as in section 152 of the 673
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as 674
amended. 675

Sec. 4121.01. (A) As used in sections 4121.01 to 4121.29 of 676
the Revised Code: 677

(1) "Place of employment" means every place, whether indoors 678
or out, or underground, and the premises appurtenant thereto, 679
where either temporarily or permanently any industry, trade, or 680

business is carried on, or where any process or operation, 681
directly or indirectly related to any industry, trade, or 682
business, is carried on and where any person is directly or 683
indirectly employed by another for direct or indirect gain or 684
profit, but does not include any place where persons are employed 685
in private domestic service or agricultural pursuits which do not 686
involve the use of mechanical power. 687

(2) "Employment" means any trade, occupation, or process of 688
manufacture or any method of carrying on such trade, occupation, 689
or process of manufacture in which any person may be engaged, 690
except in such private domestic service or agricultural pursuits 691
as do not involve the use of mechanical power. 692

(3) "Employer" means every person, firm, corporation, agent, 693
manager, representative, or other person having control or custody 694
of any employment, place of employment, or employee. 695

(4) "Employee" means every person who may be required or 696
directed by any employer, in consideration of direct or indirect 697
gain or profit, to engage in any employment, or to go, or work, or 698
be at any time in any place of employment. 699

(5) "Frequenter" means every person, other than an employee, 700
who may go in or be in a place of employment under circumstances 701
which render the person other than a trespasser. 702

(6) "Deputy" means any person employed by the industrial 703
commission or the bureau of workers' compensation, designated as a 704
deputy by the commission or the administrator of workers' 705
compensation, who possesses special, technical, scientific, 706
managerial, professional, or personal abilities or qualities in 707
matters within the jurisdiction of the commission or the bureau, 708
and who may be engaged in the performance of duties under the 709
direction of the commission or the bureau calling for the exercise 710
of such abilities or qualities. 711

(7) "Order" means any decision, rule, regulation, direction, requirement, or standard, or any other determination or decision that the bureau is empowered to and does make.

(8) "General order" means an order that applies generally throughout the state to all persons, employments, or places of employment, or all persons, employments, or places of employment of a class under the jurisdiction of the bureau. All other orders shall be considered special orders.

(9) "Local order" means any ordinance, order, rule, or determination of the legislative authority of any municipal corporation, or any trustees, or board or officers of any municipal corporation upon any matter over which the bureau has jurisdiction.

(10) "Welfare" means comfort, decency, and moral well-being.

(11) "Safe" or "safety," as applied to any employment or a place of employment, means such freedom from danger to the life, health, safety, or welfare of employees or frequenters as the nature of the employment will reasonably permit, including requirements as to the hours of labor with relation to the health and welfare of employees.

(12) "Health insurance" means any of the following:

(a) A policy, contract, or agreement entered into between a subscriber and a health insuring corporation under Chapter 1751. of the Revised Code.

(b) A policy of sickness and accident insurance delivered, issued for delivery, renewed, or used pursuant to Chapter 3923. of the Revised Code.

(c) A high deductible health plan.

(13) "Health insurer" means a health insuring corporation holding a certificate of authority under Chapter 1751. of the

Revised Code or an insurance company holding a certificate of 742
authority issued under Title XXXIX of the Revised Code. 743

(14) "Subscriber" has the same meaning as in section 1751.01 744
of the Revised Code. 745

(15) "High deductible health plan" includes either of the 746
following: 747

(a) A plan defined under section 223(c)(2) of the "Internal 748
Revenue Code of 1986," 26 U.S.C. 223, as amended. 749

(b) A plan defined under section 220(c)(2) of the "Internal 750
Revenue Code of 1986," 26 U.S.C. 223, as amended. 751

(B) As used in the Revised Code: 752

(1) "Industrial commission" means the chairperson of the 753
three-member industrial commission created pursuant to section 754
4121.02 of the Revised Code when the context refers to the 755
authority vested in the chairperson as the chief executive officer 756
of the three-member industrial commission pursuant to divisions 757
(A), (B), (C), and (D) of section 4121.03 of the Revised Code. 758

(2) "Industrial commission" means the three-member industrial 759
commission created pursuant to section 4121.02 of the Revised Code 760
when the context refers to the authority vested in the 761
three-member industrial commission pursuant to division (E) of 762
section 4121.03 of the Revised Code. 763

(3) "Industrial commission" means the industrial commission 764
as a state agency when the context refers to the authority vested 765
in the industrial commission as a state agency. 766

Sec. 4121.44. (A) The administrator of workers' compensation 767
shall oversee the implementation of the Ohio workers' compensation 768
qualified health plan system as established under section 4121.442 769
of the Revised Code. 770

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau of workers' compensation as set forth in section 4121.441 of the Revised Code. To implement the health partnership program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify external vendors for additional periods of two years; and

(3) May integrate the certified vendors with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section.

(C) Any vendor selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional and pharmacy providers currently being utilized by claimants.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the vendor's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a

statewide basis have access to the eligibility and pricing, at a 801
discounted rate, of all prescription drugs. 802

(5) A tracking system to record all telephone calls from 803
claimants and providers regarding the status of submitted medical 804
bills so as to be able to track each inquiry. 805

(6) Data processing capacity to absorb all of the bureau's 806
medical bill processing or at least that part of the processing 807
which the bureau arranges to delegate. 808

(7) Capacity to store, retrieve, array, simulate, and model 809
in a relational mode all of the detailed medical bill data so that 810
analysis can be performed in a variety of ways and so that the 811
bureau and its governing authority can make informed decisions. 812

(8) Wide variety of software programs which translate medical 813
terminology into standard codes, and which reveal if a provider is 814
manipulating the procedures codes, commonly called "unbundling." 815

(9) Necessary professional staff to conduct, at a minimum, 816
authorizations for treatment, medical necessity, utilization 817
review, concurrent review, post-utilization review, and have the 818
attendant computer system which supports such activity and 819
measures the outcomes and the savings. 820

(10) Management experience and flexibility to be able to 821
react quickly to the needs of the bureau in the case of required 822
change in federal or state requirements. 823

(D)(1) Information contained in a vendor's application for 824
certification in the health partnership program, and other 825
information furnished to the bureau by a vendor for purposes of 826
obtaining certification or to comply with performance and 827
financial auditing requirements established by the administrator, 828
is for the exclusive use and information of the bureau in the 829
discharge of its official duties, and shall not be open to the 830
public or be used in any court in any proceeding pending therein, 831

unless the bureau is a party to the action or proceeding, but the 832
information may be tabulated and published by the bureau in 833
statistical form for the use and information of other state 834
departments and the public. No employee of the bureau, except as 835
otherwise authorized by the administrator, shall divulge any 836
information secured by the employee while in the employ of the 837
bureau in respect to a vendor's application for certification or 838
in respect to the business or other trade processes of any vendor 839
to any person other than the administrator or to the employee's 840
superior. 841

(2) Notwithstanding the restrictions imposed by division 842
(D)(1) of this section, the governor, members of select or 843
standing committees of the senate or house of representatives, the 844
auditor of state, the attorney general, or their designees, 845
pursuant to the authority granted in this chapter and Chapter 846
4123. of the Revised Code, may examine any vendor application or 847
other information furnished to the bureau by the vendor. None of 848
those individuals shall divulge any information secured in the 849
exercise of that authority in respect to a vendor's application 850
for certification or in respect to the business or other trade 851
processes of any vendor to any person. 852

(E) On and after January 1, 2001, a vendor shall not be any 853
insurance company holding a certificate of authority issued 854
pursuant to Title XXXIX of the Revised Code or any health insuring 855
corporation holding a certificate of authority under Chapter 1751. 856
of the Revised Code. 857

~~(F) The administrator may limit freedom of choice of health 858
care provider or supplier by requiring, beginning with the period 859
set forth in division (B)(1) or (2) of this section, that 860
claimants shall pay an appropriate out-of-plan copayment for 861
selecting a medical provider not within the health partnership 862
program as provided for in this section. 863~~

~~(G)~~ The administrator, six months prior to the expiration of the bureau's certification or recertification of the vendor or vendors as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the external vendor or vendors and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

~~(H)~~(G) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers and medical providers, medical vendors, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected vendor or vendors and to measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data to the governor, the speaker of the house of representatives, and the president of the senate on the first day of each January and July, the measures of outcomes and savings of the health partnership program. The administrator shall protect the confidentiality of all proprietary pricing data.

~~(I)~~(H) Any rehabilitation facility the bureau operates is

eligible for inclusion in the Ohio workers' compensation qualified 895
health plan system or the health partnership program under the 896
same terms as other providers within health care plans or the 897
program. 898

~~(J) In areas outside the state or within the state where no 899
qualified health plan or an inadequate number of providers within 900
the health partnership program exist, the administrator shall 901
permit employees to use a nonplan or nonprogram health care 902
provider and shall pay the provider for the services or supplies 903
provided to or on behalf of an employee for an injury or 904
occupational disease that is compensable under this chapter or 905
Chapter 4123., 4127., or 4131. of the Revised Code on a fee 906
schedule the administrator adopts. 907~~

~~(K)(I) No health care provider, whether certified or not, 908
shall charge, assess, or otherwise attempt to collect from an 909
employee, employer, a managed care organization, or the bureau any 910
amount for covered services or supplies that is in excess of the 911
allowed amount paid by a managed care organization, the bureau, or 912
a qualified health plan, except that a health care provider may 913
charge or assess an employee a copayment or deductible in 914
accordance with section 4123.513 of the Revised Code. 915~~

~~(L)(J) The administrator shall permit any employer or group 916
of employers who agree to abide by the rules adopted under this 917
section and sections 4121.441 and 4121.442 of the Revised Code to 918
provide services or supplies to or on behalf of an employee for an 919
injury or occupational disease that is compensable under this 920
chapter or Chapter 4123., 4127., or 4131. of the Revised Code 921
through qualified health plans of the Ohio workers' compensation 922
qualified health plan system pursuant to section 4121.442 of the 923
Revised Code or through the health partnership program pursuant to 924
section 4121.441 of the Revised Code. No amount paid under the 925
qualified health plan system pursuant to section 4121.442 of the 926~~

Revised Code by an employer who is a state fund employer shall be 927
charged to the employer's experience or otherwise be used in 928
merit-rating or determining the risk of that employer for the 929
purpose of the payment of premiums under this chapter, and if the 930
employer is a self-insuring employer, the employer shall not 931
include that amount in the paid compensation the employer reports 932
under section 4123.35 of the Revised Code. 933

Sec. 4121.441. (A) The administrator of workers' 934
compensation, with the advice and consent of the workers' 935
compensation oversight commission, shall adopt rules under Chapter 936
119. of the Revised Code for the health care partnership program 937
administered by the bureau of workers' compensation to provide 938
medical, surgical, nursing, drug, hospital, and rehabilitation 939
services and supplies to an employee for an injury or occupational 940
disease that is compensable under this chapter or Chapter 4123., 941
4127., or 4131. of the Revised Code. 942

The rules shall include, but are not limited to, the 943
following: 944

(1) Procedures for the resolution of medical disputes between 945
an employer and an employee, an employee and a provider, or an 946
employer and a provider, prior to an appeal under section 4123.511 947
of the Revised Code. Rules the administrator adopts pursuant to 948
division (A)(1) of this section may specify that the resolution 949
procedures shall not be used to resolve disputes concerning 950
medical services rendered that have been approved through standard 951
treatment guidelines, pathways, or presumptive authorization 952
guidelines. 953

(2) Prohibitions against discrimination against any category 954
of health care providers; 955

(3) Procedures for reporting injuries to employers and the 956
bureau by providers; 957

(4) Appropriate financial incentives to reduce service cost	958
and insure proper system utilization without sacrificing the	959
quality of service;	960
(5) Adequate methods of peer review, utilization review,	961
quality assurance, and dispute resolution to prevent, and provide	962
sanctions for, inappropriate, excessive or not medically necessary	963
treatment;	964
(6) A timely and accurate method of collection of necessary	965
information regarding medical and health care service and supply	966
costs, quality, and utilization to enable the administrator to	967
determine the effectiveness of the program;	968
(7) Provisions for necessary emergency medical treatment for	969
an injury or occupational disease provided by a health care	970
provider who is not part of the program;	971
(8) Discounted pricing for all in-patient and out-patient	972
medical services, all professional services, and all	973
pharmaceutical services;	974
(9) Provisions for provider referrals, pre-admission and	975
post-admission approvals, second surgical opinions, and other cost	976
management techniques;	977
(10) Antifraud mechanisms;	978
(11) Standards and criteria for the bureau to utilize in	979
certifying or recertifying a health care provider or a vendor for	980
participation in the health partnership program;	981
(12) Standards and criteria for the bureau to utilize in	982
penalizing or decertifying a health care provider or a vendor from	983
participation in the health partnership program;	984
<u>(13) Methods to coordinate benefits provided by a health care</u>	985
<u>provider when a health insurer or employee is paying the bills</u>	986
<u>incurred in a claim pursuant to section 4123.513 of the Revised</u>	987

Code and prior to a final determination of the employee's 988
eligibility to receive workers' compensation benefits under 989
section 4123.511 or 4123.512 of the Revised Code; 990

(14) Methods to determine the amount a health insurer or 991
employee shall pay a health care provider for medical bills 992
incurred in the employee's claim prior to a final determination of 993
the employee's eligibility to receive workers' compensation 994
benefits under section 4123.511 or 4123.512 of the Revised Code; 995

(15) Methods to determine the amount a health care provider 996
shall be paid after a final determination has been made concerning 997
an employee's eligibility to receive compensation and benefits 998
under this chapter or Chapter 4123., 4127., or 4131. of the 999
Revised Code; 1000

(16) Methods to determine the amount the bureau shall 1001
reimburse a health insurer or employee for payment of medical 1002
bills for a claim after a final determination has been made that 1003
the employee is eligible to receive compensation and benefits 1004
under this chapter or Chapter 4123., 4127., or 4131. of the 1005
Revised Code. 1006

(B) The administrator shall implement the health partnership 1007
program according to the rules the administrator adopts under this 1008
section for the provision and payment of medical, surgical, 1009
nursing, drug, hospital, and rehabilitation services and supplies 1010
to an employee for an injury or occupational disease that is 1011
compensable under this chapter or Chapter 4123., 4127., or 4131. 1012
of the Revised Code. 1013

Sec. 4121.442. (A) The administrator of workers' compensation 1014
shall develop standards for qualification of health care plans of 1015
the Ohio workers' compensation qualified health plan system to 1016
provide medical, surgical, nursing, drug, hospital, and 1017
rehabilitation services and supplies to an employee for an injury 1018

or occupational disease that is compensable under this chapter or 1019
Chapter 4123., 4127., or 4131. of the Revised Code. In adopting 1020
the standards, the administrator shall use nationally recognized 1021
accreditation standards. The standards the administrator adopts 1022
must provide that a qualified plan provides for all of the 1023
following: 1024

(1) Criteria for selective contracting of health care 1025
providers; 1026

(2) Adequate plan structure and financial stability; 1027

(3) Procedures for the resolution of medical disputes between 1028
an employee and an employer, an employee and a provider, or an 1029
employer and a provider, prior to an appeal under section 4123.511 1030
of the Revised Code; 1031

(4) Authorize employees who are dissatisfied with the health 1032
care services of the employer's qualified plan and do not wish to 1033
obtain treatment under the provisions of this section, to request 1034
the administrator for referral to a health care provider in the 1035
bureau's health care partnership program. The administrator must 1036
refer all requesting employees into the health care partnership 1037
program. 1038

(5) Authorize employees to select a health care provider who 1039
is not included in the employer's qualified plan if the employee 1040
is receiving services from that health care provider pursuant to 1041
section 4123.513 of the Revised Code. 1042

(6) Does not discriminate against any category of health care 1043
provider; 1044

~~(6)~~(7) Provide a procedure for reporting injuries to the 1045
bureau of workers' compensation and to employers by providers 1046
within the qualified plan; 1047

~~(7)~~(8) Provide appropriate financial incentives to reduce 1048

service costs and utilization without sacrificing the quality of 1049
service; 1050

~~(8)~~(9) Provide adequate methods of peer review, utilization 1051
review, quality assurance, and dispute resolution to prevent and 1052
provide sanctions for inappropriate, excessive, or not medically 1053
necessary treatment; 1054

~~(9)~~(10) Provide a timely and accurate method of reporting to 1055
the administrator necessary information regarding medical and 1056
health care service and supply costs, quality, and utilization to 1057
enable the administrator to determine the effectiveness of the 1058
plan; 1059

~~(10)~~(11) Authorize necessary emergency medical treatment for 1060
an injury or occupational disease provided by a health care 1061
provider who is not a part of the qualified health care plan; 1062

~~(11)~~(12) Provide an employee the right to change health care 1063
providers within the qualified health care plan; 1064

~~(12)~~(13) Provide for standardized data and reporting 1065
requirements; 1066

~~(13)~~(14) Authorize necessary medical treatment for employees 1067
who work in Ohio but reside in another state; 1068

(15) Establish methods to coordinate benefits provided by a 1069
health care provider when a health insurer or employee is paying 1070
the bills incurred in a claim pursuant to section 4123.513 of the 1071
Revised Code and prior to a final determination of the employee's 1072
eligibility to receive workers' compensation benefits under 1073
section 4123.511 or 4123.512 of the Revised Code; 1074

(16) Establish methods to determine the amount a health 1075
insurer or employee shall pay a health care provider for medical 1076
bills incurred in the employee's claim prior to a final 1077
determination of the employee's eligibility to receive workers' 1078

compensation benefits under section 4123.511 or 4123.512 of the 1079
Revised Code; 1080

(17) Establish methods to determine the amount a health care 1081
provider shall be paid after a final determination has been made, 1082
concerning an employee's eligibility to receive compensation and 1083
benefits under this chapter or Chapter 4123., 4127., or 4131. of 1084
the Revised Code; 1085

(18) Establish methods to determine the amount the bureau 1086
shall reimburse a health insurer or employee for payment of 1087
medical bills for a claim after a final determination has been 1088
made that the employee is eligible to receive compensation and 1089
benefits under this chapter or Chapter 4123., 4127., or 4131. of 1090
the Revised Code. 1091

(B) Health care plans that meet the approved qualified health 1092
plan standards shall be considered qualified plans and are 1093
eligible to become part of the Ohio workers' compensation 1094
qualified health plan system. Any employer or group of employers 1095
may provide medical, surgical, nursing, drug, hospital, and 1096
rehabilitation services and supplies to an employee for an injury 1097
or occupational disease that is compensable under this chapter or 1098
Chapter 4123., 4127., or 4131. of the Revised Code through a 1099
qualified health plan. 1100

Sec. 4123.01. As used in this chapter: 1101

(A)(1) "Employee" means: 1102

(a) Every person in the service of the state, or of any 1103
county, municipal corporation, township, or school district 1104
therein, including regular members of lawfully constituted police 1105
and fire departments of municipal corporations and townships, 1106
whether paid or volunteer, and wherever serving within the state 1107
or on temporary assignment outside thereof, and executive officers 1108

of boards of education, under any appointment or contract of hire, 1109
express or implied, oral or written, including any elected 1110
official of the state, or of any county, municipal corporation, or 1111
township, or members of boards of education. 1112

As used in division (A)(1)(a) of this section, the term 1113
"employee" includes the following persons when responding to an 1114
inherently dangerous situation that calls for an immediate 1115
response on the part of the person, regardless of whether the 1116
person is within the limits of the jurisdiction of the person's 1117
regular employment or voluntary service when responding, on the 1118
condition that the person responds to the situation as the person 1119
otherwise would if the person were on duty in the person's 1120
jurisdiction: 1121

(i) Off-duty peace officers. As used in division (A)(1)(a)(i) 1122
of this section, "peace officer" has the same meaning as in 1123
section 2935.01 of the Revised Code. 1124

(ii) Off-duty firefighters, whether paid or volunteer, of a 1125
lawfully constituted fire department. 1126

(iii) Off-duty first responders, emergency medical 1127
technicians-basic, emergency medical technicians-intermediate, or 1128
emergency medical technicians-paramedic, whether paid or 1129
volunteer, of an ambulance service organization or emergency 1130
medical service organization pursuant to Chapter 4765. of the 1131
Revised Code. 1132

(b) Every person in the service of any person, firm, or 1133
private corporation, including any public service corporation, 1134
that (i) employs one or more persons regularly in the same 1135
business or in or about the same establishment under any contract 1136
of hire, express or implied, oral or written, including aliens and 1137
minors, household workers who earn one hundred sixty dollars or 1138
more in cash in any calendar quarter from a single household and 1139

casual workers who earn one hundred sixty dollars or more in cash 1140
in any calendar quarter from a single employer, or (ii) is bound 1141
by any such contract of hire or by any other written contract, to 1142
pay into the state insurance fund the premiums provided by this 1143
chapter. 1144

(c) Every person who performs labor or provides services 1145
pursuant to a construction contract, as defined in section 4123.79 1146
of the Revised Code, if at least ten of the following criteria 1147
apply: 1148

(i) The person is required to comply with instructions from 1149
the other contracting party regarding the manner or method of 1150
performing services; 1151

(ii) The person is required by the other contracting party to 1152
have particular training; 1153

(iii) The person's services are integrated into the regular 1154
functioning of the other contracting party; 1155

(iv) The person is required to perform the work personally; 1156

(v) The person is hired, supervised, or paid by the other 1157
contracting party; 1158

(vi) A continuing relationship exists between the person and 1159
the other contracting party that contemplates continuing or 1160
recurring work even if the work is not full time; 1161

(vii) The person's hours of work are established by the other 1162
contracting party; 1163

(viii) The person is required to devote full time to the 1164
business of the other contracting party; 1165

(ix) The person is required to perform the work on the 1166
premises of the other contracting party; 1167

(x) The person is required to follow the order of work set by 1168
the other contracting party; 1169

(xi) The person is required to make oral or written reports	1170
of progress to the other contracting party;	1171
(xii) The person is paid for services on a regular basis such	1172
as hourly, weekly, or monthly;	1173
(xiii) The person's expenses are paid for by the other	1174
contracting party;	1175
(xiv) The person's tools and materials are furnished by the	1176
other contracting party;	1177
(xv) The person is provided with the facilities used to	1178
perform services;	1179
(xvi) The person does not realize a profit or suffer a loss	1180
as a result of the services provided;	1181
(xvii) The person is not performing services for a number of	1182
employers at the same time;	1183
(xviii) The person does not make the same services available	1184
to the general public;	1185
(xix) The other contracting party has a right to discharge	1186
the person;	1187
(xx) The person has the right to end the relationship with	1188
the other contracting party without incurring liability pursuant	1189
to an employment contract or agreement.	1190
Every person in the service of any independent contractor or	1191
subcontractor who has failed to pay into the state insurance fund	1192
the amount of premium determined and fixed by the administrator of	1193
workers' compensation for the person's employment or occupation or	1194
if a self-insuring employer has failed to pay compensation and	1195
benefits directly to the employer's injured and to the dependents	1196
of the employer's killed employees as required by section 4123.35	1197
of the Revised Code <u>or to reimburse directly a health insurer or</u>	1198
<u>employee pursuant to section 4123.513 of the Revised Code</u> , shall	1199

be considered as the employee of the person who has entered into a contract, whether written or verbal, with such independent contractor unless such employees or their legal representatives or beneficiaries elect, after injury or death, to regard such independent contractor as the employer.

(2) "Employee" does not mean:

(a) A duly ordained, commissioned, or licensed minister or assistant or associate minister of a church in the exercise of ministry;

(b) Any officer of a family farm corporation;

(c) An individual incorporated as a corporation; or

(d) An individual who otherwise is an employee of an employer but who signs the waiver and affidavit specified in section 4123.15 of the Revised Code on the condition that the administrator has granted a waiver and exception to the individual's employer under section 4123.15 of the Revised Code.

Any employer may elect to include as an "employee" within this chapter, any person excluded from the definition of "employee" pursuant to division (A)(2) of this section. If an employer is a partnership, sole proprietorship, individual incorporated as a corporation, or family farm corporation, such employer may elect to include as an "employee" within this chapter, any member of such partnership, the owner of the sole proprietorship, the individual incorporated as a corporation, or the officers of the family farm corporation. In the event of an election, the employer shall serve upon the bureau of workers' compensation written notice naming the persons to be covered, include such employee's remuneration for premium purposes in all future payroll reports, and no person excluded from the definition of "employee" pursuant to division (A)(2) of this section, proprietor, individual incorporated as a corporation, or partner

shall be deemed an employee within this division until the 1231
employer has served such notice. 1232

For informational purposes only, the bureau shall prescribe 1233
such language as it considers appropriate, on such of its forms as 1234
it considers appropriate, to advise employers of their right to 1235
elect to include as an "employee" within this chapter a sole 1236
proprietor, any member of a partnership, an individual 1237
incorporated as a corporation, the officers of a family farm 1238
corporation, or a person excluded from the definition of 1239
"employee" under division (A)(2) of this section, that they should 1240
check any health and disability insurance policy, or other form of 1241
health and disability plan or contract, presently covering them, 1242
or the purchase of which they may be considering, to determine 1243
whether such policy, plan, or contract excludes benefits for 1244
illness or injury that they might have elected to have covered by 1245
workers' compensation. 1246

(B) "Employer" means: 1247

(1) The state, including state hospitals, each county, 1248
municipal corporation, township, school district, and hospital 1249
owned by a political subdivision or subdivisions other than the 1250
state; 1251

(2) Every person, firm, professional employer organization as 1252
defined in section 4125.01 of the Revised Code, and private 1253
corporation, including any public service corporation, that (a) 1254
has in service one or more employees or shared employees regularly 1255
in the same business or in or about the same establishment under 1256
any contract of hire, express or implied, oral or written, or (b) 1257
is bound by any such contract of hire or by any other written 1258
contract, to pay into the insurance fund the premiums provided by 1259
this chapter. 1260

All such employers are subject to this chapter. Any member of 1261

a firm or association, who regularly performs manual labor in or 1262
about a mine, factory, or other establishment, including a 1263
household establishment, shall be considered an employee in 1264
determining whether such person, firm, or private corporation, or 1265
public service corporation, has in its service, one or more 1266
employees and the employer shall report the income derived from 1267
such labor to the bureau as part of the payroll of such employer, 1268
and such member shall thereupon be entitled to all the benefits of 1269
an employee. 1270

(C) "Injury" includes any injury, whether caused by external 1271
accidental means or accidental in character and result, received 1272
in the course of, and arising out of, the injured employee's 1273
employment. "Injury" does not include: 1274

(1) Psychiatric conditions except where the claimant's 1275
psychiatric conditions have arisen from an injury or occupational 1276
disease sustained by that claimant or where the claimant's 1277
psychiatric conditions have arisen from sexual conduct in which 1278
the claimant was forced by threat of physical harm to engage or 1279
participate; 1280

(2) Injury or disability caused primarily by the natural 1281
deterioration of tissue, an organ, or part of the body; 1282

(3) Injury or disability incurred in voluntary participation 1283
in an employer-sponsored recreation or fitness activity if the 1284
employee signs a waiver of the employee's right to compensation or 1285
benefits under this chapter prior to engaging in the recreation or 1286
fitness activity; 1287

(4) A condition that pre-existed an injury unless that 1288
pre-existing condition is substantially aggravated by the injury. 1289
Such a substantial aggravation must be documented by objective 1290
diagnostic findings, objective clinical findings, or objective 1291
test results. Subjective complaints may be evidence of such a 1292

substantial aggravation. However, subjective complaints without 1293
objective diagnostic findings, objective clinical findings, or 1294
objective test results are insufficient to substantiate a 1295
substantial aggravation. 1296

(D) "Child" includes a posthumous child and a child legally 1297
adopted prior to the injury. 1298

(E) "Family farm corporation" means a corporation founded for 1299
the purpose of farming agricultural land in which the majority of 1300
the voting stock is held by and the majority of the stockholders 1301
are persons or the spouse of persons related to each other within 1302
the fourth degree of kinship, according to the rules of the civil 1303
law, and at least one of the related persons is residing on or 1304
actively operating the farm, and none of whose stockholders are a 1305
corporation. A family farm corporation does not cease to qualify 1306
under this division where, by reason of any devise, bequest, or 1307
the operation of the laws of descent or distribution, the 1308
ownership of shares of voting stock is transferred to another 1309
person, as long as that person is within the degree of kinship 1310
stipulated in this division. 1311

(F) "Occupational disease" means a disease contracted in the 1312
course of employment, which by its causes and the characteristics 1313
of its manifestation or the condition of the employment results in 1314
a hazard which distinguishes the employment in character from 1315
employment generally, and the employment creates a risk of 1316
contracting the disease in greater degree and in a different 1317
manner from the public in general. 1318

(G) "Self-insuring employer" means an employer who is granted 1319
the privilege of paying compensation and benefits directly under 1320
section 4123.35 of the Revised Code, including a board of county 1321
commissioners for the sole purpose of constructing a sports 1322
facility as defined in section 307.696 of the Revised Code, 1323
provided that the electors of the county in which the sports 1324

facility is to be built have approved construction of a sports 1325
facility by ballot election no later than November 6, 1997. 1326

(H) "Public employer" means an employer as defined in 1327
division (B)(1) of this section. 1328

(I) "Sexual conduct" means vaginal intercourse between a male 1329
and female; anal intercourse, fellatio, and cunnilingus between 1330
persons regardless of gender; and, without privilege to do so, the 1331
insertion, however slight, of any part of the body or any 1332
instrument, apparatus, or other object into the vaginal or anal 1333
cavity of another. Penetration, however slight, is sufficient to 1334
complete vaginal or anal intercourse. 1335

(J) "Health insurance," "health insurer," "subscriber," and 1336
"high deductible health plan" have the same meanings as in section 1337
4121.01 of the Revised Code. 1338

Sec. 4123.30. Money contributed by the employers mentioned in 1339
division (B)(1) of section 4123.01 of the Revised Code constitutes 1340
the "public fund" and the money contributed by employers mentioned 1341
in division (B)(2) of such section constitutes the "private fund." 1342
Each such fund shall be collected, distributed, and its solvency 1343
maintained without regard to or reliance upon the other. Whenever 1344
in this chapter reference is made to the state insurance fund, the 1345
reference is to such two separate funds but such two separate 1346
funds and the net premiums contributed thereto by employers after 1347
adjustments and dividends, except for the amount thereof which is 1348
set aside for the investigation and prevention of industrial 1349
accidents and diseases pursuant to Section 35 of Article II, Ohio 1350
Constitution, any amounts set aside for actuarial services 1351
authorized or required by sections 4123.44 and 4123.47 of the 1352
Revised Code, and any amounts set aside to reinsure the liability 1353
of the respective insurance funds for the following payments, 1354
constitute a trust fund for the benefit of employers and employees 1355

mentioned in sections 4123.01, 4123.03, and 4123.73 of the Revised Code for the payment of compensation, medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, rehabilitation, death benefits, funeral expenses, and like benefits for loss sustained on account of injury, disease, or death provided for by this chapter, for reimbursements to health insurers and employees for bills for medical benefits that the health insurer or employee paid pursuant to section 4123.513 of the Revised Code, and for no other purpose. This section does not prevent the deposit or investment of all such moneys intermingled for such purpose but such funds shall be separate and distinct for all other purposes, and the rights and duties created in this chapter shall be construed to have been made with respect to two separate funds and so as to maintain and continue such funds separately except for deposit or investment. Disbursements shall not be made on account of injury, disease, or death of employees of employers who contribute to one of such funds unless the moneys to the credit of such fund are sufficient therefor and no such disbursements shall be made for moneys or credits paid or credited to the other fund.

Sec. 4123.343. This section shall be construed liberally to the end that employers shall be encouraged to employ and retain in their employment handicapped employees as defined in this section.

(A) As used in this section, "handicapped employee" means an employee who is afflicted with or subject to any physical or mental impairment, or both, whether congenital or due to an injury or disease of such character that the impairment constitutes a handicap in obtaining employment or would constitute a handicap in obtaining reemployment if the employee should become unemployed and whose handicap is due to any of the following diseases or conditions:

(1) Epilepsy;	1388
(2) Diabetes;	1389
(3) Cardiac disease;	1390
(4) Arthritis;	1391
(5) Amputated foot, leg, arm, or hand;	1392
(6) Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than seventy-five per cent bilaterally;	1393 1394
(7) Residual disability from poliomyelitis;	1395
(8) Cerebral palsy;	1396
(9) Multiple sclerosis;	1397
(10) Parkinson's disease;	1398
(11) Cerebral vascular accident;	1399
(12) Tuberculosis;	1400
(13) Silicosis;	1401
(14) Psycho-neurotic disability following treatment in a recognized medical or mental institution;	1402 1403
(15) Hemophilia;	1404
(16) Chronic osteomyelitis;	1405
(17) Ankylosis of joints;	1406
(18) Hyper insulinism;	1407
(19) Muscular dystrophies;	1408
(20) Arterio-sclerosis;	1409
(21) Thrombo-phlebitis;	1410
(22) Varicose veins;	1411
(23) Cardiovascular, pulmonary, or respiratory diseases of a firefighter or police officer employed by a municipal corporation	1412 1413

or township as a regular member of a lawfully constituted police 1414
department or fire department; 1415

(24) Coal miners' pneumoconiosis, commonly referred to as 1416
"black lung disease"; 1417

(25) Disability with respect to which an individual has 1418
completed a rehabilitation program conducted pursuant to sections 1419
4121.61 to 4121.69 of the Revised Code. 1420

(B) Under the circumstances set forth in this section all or 1421
such portion as the administrator determines of the compensation 1422
and benefits paid in any claim arising hereafter shall be charged 1423
to and paid from the statutory surplus fund created under section 1424
4123.34 of the Revised Code and only the portion remaining shall 1425
be merit-rated or otherwise treated as part of the accident or 1426
occupational disease experience of the employer. If the employer 1427
is a self-insuring employer, the proportion of such costs whether 1428
charged to the statutory surplus fund in whole or in part shall be 1429
by way of ~~direct~~ payment to such employee, the employee's health 1430
insurer, or the employee's dependents or by way of reimbursement 1431
to the self-insuring employer as the circumstances indicate. The 1432
provisions of this section apply only in cases of death, total 1433
disability, whether temporary or permanent, and all disabilities 1434
compensated under division (B) of section 4123.57 of the Revised 1435
Code. The administrator shall adopt rules specifying the grounds 1436
upon which charges to the statutory surplus fund are to be made. 1437
The rules shall prohibit as a grounds any agreement between 1438
employer and claimant as to the merits of a claim and the amount 1439
of the charge. 1440

(C) Any employer who has in its employ a handicapped employee 1441
is entitled, in the event the person is injured, to a 1442
determination under this section. 1443

An employer shall file an application under this section for 1444

a determination with the bureau or commission in the same manner 1445
as other claims. An application only may be made in cases where a 1446
handicapped employee or a handicapped employee's dependents claim 1447
or ~~is~~ are receiving an award of compensation as a result of an 1448
injury or occupational disease occurring or contracted on or after 1449
the date on which division (A) of this section first included the 1450
handicap of such employee. 1451

(D) The circumstances under and the manner in which an 1452
apportionment under this section shall be made are: 1453

(1) Whenever a handicapped employee is injured or disabled or 1454
dies as the result of an injury or occupational disease sustained 1455
in the course of and arising out of a handicapped employee's 1456
employment in this state and the administrator awards compensation 1457
therefor and when it appears to the satisfaction of the 1458
administrator that the injury or occupational disease or the death 1459
resulting therefrom would not have occurred but for the 1460
pre-existing physical or mental impairment of the handicapped 1461
employee, all compensation and benefits payable on account of the 1462
disability or death shall be paid from the surplus fund. 1463

(2) Whenever a handicapped employee is injured or disabled or 1464
dies as a result of an injury or occupational disease and the 1465
administrator finds that the injury or occupational disease would 1466
have been sustained or suffered without regard to the employee's 1467
pre-existing impairment but that the resulting disability or death 1468
was caused at least in part through aggravation of the employee's 1469
pre-existing disability, the administrator shall determine in a 1470
manner that is equitable and reasonable and based upon medical 1471
evidence the amount of disability or proportion of the cost of the 1472
death award that is attributable to the employee's pre-existing 1473
disability and the amount found shall be charged to the statutory 1474
surplus fund. 1475

(E) The benefits and provisions of this section apply only to 1476

employers who have complied with this chapter either through 1477
insurance with the state fund or as a self-insuring employer. 1478

(F) No employer shall in any year receive credit under this 1479
section in an amount greater than the premium the employer paid if 1480
a state fund employer or greater than the employer's assessments 1481
if a self-insuring employer. 1482

(G) Self-insuring employers may, for all claims made after 1483
January 1, 1987, for compensation and benefits under this section, 1484
pay the compensation and benefits directly to the employee or the 1485
employee's dependents, or directly reimburse a health insurer 1486
pursuant to section 4123.513 of the Revised Code. If such an 1487
employer chooses to pay compensation and benefits directly, the 1488
employer shall receive no money or credit from the surplus fund 1489
for the payment under this section, nor shall the employer be 1490
required to pay any amounts into the surplus fund that otherwise 1491
would be assessed for handicapped reimbursements for claims made 1492
after January 1, 1987. Where a self-insuring employer elects to 1493
pay for compensation and benefits pursuant to this section, the 1494
employer shall assume responsibility for compensation and benefits 1495
arising out of claims made prior to January 1, 1987, and shall not 1496
be required to pay any amounts into the surplus fund and may not 1497
receive any money or credit from that fund on account of this 1498
section. The election made under this division is irrevocable. 1499

(H) An order issued by the administrator pursuant to this 1500
section is appealable under section 4123.511 of the Revised Code 1501
but is not appealable to court under section 4123.512 of the 1502
Revised Code. 1503

Sec. 4123.35. (A) Except as provided in this section, every 1504
employer mentioned in division (B)(2) of section 4123.01 of the 1505
Revised Code, and every publicly owned utility shall pay 1506
semiannually in the months of January and July into the state 1507

insurance fund the amount of annual premium the administrator of 1508
workers' compensation fixes for the employment or occupation of 1509
the employer, the amount of which premium to be paid by each 1510
employer to be determined by the classifications, rules, and rates 1511
made and published by the administrator. The employer shall pay 1512
semiannually a further sum of money into the state insurance fund 1513
as may be ascertained to be due from the employer by applying the 1514
rules of the administrator, and a receipt or certificate 1515
certifying that payment has been made, along with a written notice 1516
as is required in section 4123.54 of the Revised Code, shall be 1517
mailed immediately to the employer by the bureau of workers' 1518
compensation. The receipt or certificate is prima-facie evidence 1519
of the payment of the premium, and the proper posting of the 1520
notice constitutes the employer's compliance with the notice 1521
requirement mandated in section 4123.54 of the Revised Code. 1522

The bureau of workers' compensation shall verify with the 1523
secretary of state the existence of all corporations and 1524
organizations making application for workers' compensation 1525
coverage and shall require every such application to include the 1526
employer's federal identification number. 1527

An employer as defined in division (B)(2) of section 4123.01 1528
of the Revised Code who has contracted with a subcontractor is 1529
liable for the unpaid premium due from any subcontractor with 1530
respect to that part of the payroll of the subcontractor that is 1531
for work performed pursuant to the contract with the employer. 1532

Division (A) of this section providing for the payment of 1533
premiums semiannually does not apply to any employer who was a 1534
subscriber to the state insurance fund prior to January 1, 1914, 1535
or who may first become a subscriber to the fund in any month 1536
other than January or July. Instead, the semiannual premiums shall 1537
be paid by those employers from time to time upon the expiration 1538
of the respective periods for which payments into the fund have 1539

been made by them. 1540

The administrator shall adopt rules to permit employers to 1541
make periodic payments of the semiannual premium due under this 1542
division. The rules shall include provisions for the assessment of 1543
interest charges, where appropriate, and for the assessment of 1544
penalties when an employer fails to make timely premium payments. 1545
An employer who timely pays the amounts due under this division is 1546
entitled to all of the benefits and protections of this chapter. 1547
Upon receipt of payment, the bureau immediately shall mail a 1548
receipt or certificate to the employer certifying that payment has 1549
been made, which receipt is prima-facie evidence of payment. 1550
Workers' compensation coverage under this chapter continues 1551
uninterrupted upon timely receipt of payment under this division. 1552

Every public employer, except public employers that are 1553
self-insuring employers under this section, shall comply with 1554
sections 4123.38 to 4123.41, and 4123.48 of the Revised Code in 1555
regard to the contribution of moneys to the public insurance fund. 1556

(B) Employers who will abide by the rules of the 1557
administrator and who may be of sufficient financial ability to 1558
render certain the payment of compensation to injured employees or 1559
the dependents of killed employees, and the furnishing of medical, 1560
surgical, nursing, and hospital attention and services and 1561
medicines, and funeral expenses, equal to or greater than is 1562
provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 1563
to 4123.67 of the Revised Code, and who do not desire to insure 1564
the payment thereof or indemnify themselves against loss sustained 1565
by the direct payment thereof, upon a finding of such facts by the 1566
administrator, may be granted the privilege to pay individually 1567
compensation, and furnish medical, surgical, nursing, and hospital 1568
services and attention and funeral expenses directly to injured 1569
employees or the dependents of killed employees, or to reimburse a 1570
health insurer or an employee who paid a health care provider for 1571

medical benefits provided by that health care provider, pursuant 1572
to section 4123.513 of the Revised Code, thereby being granted 1573
status as a self-insuring employer. The administrator may charge 1574
employers who apply for the status as a self-insuring employer a 1575
reasonable application fee to cover the bureau's costs in 1576
connection with processing and making a determination with respect 1577
to an application. 1578

All employers granted status as self-insuring employers shall 1579
demonstrate sufficient financial and administrative ability to 1580
assure that all obligations under this section are promptly met. 1581
The administrator shall deny the privilege where the employer is 1582
unable to demonstrate the employer's ability to promptly meet all 1583
the obligations imposed on the employer by this section. 1584

(1) The administrator shall consider, but is not limited to, 1585
the following factors, where applicable, in determining the 1586
employer's ability to meet all of the obligations imposed on the 1587
employer by this section: 1588

(a) The employer employs a minimum of five hundred employees 1589
in this state; 1590

(b) The employer has operated in this state for a minimum of 1591
two years, provided that an employer who has purchased, acquired, 1592
or otherwise succeeded to the operation of a business, or any part 1593
thereof, situated in this state that has operated for at least two 1594
years in this state, also shall qualify; 1595

(c) Where the employer previously contributed to the state 1596
insurance fund or is a successor employer as defined by bureau 1597
rules, the amount of the buyout, as defined by bureau rules; 1598

(d) The sufficiency of the employer's assets located in this 1599
state to insure the employer's solvency in paying compensation 1600
directly; 1601

(e) The financial records, documents, and data, certified by 1602

a certified public accountant, necessary to provide the employer's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(f) The employer's organizational plan for the administration of the workers' compensation law;

(g) The employer's proposed plan to inform employees of the change from a state fund insurer to a self-insuring employer, the procedures the employer will follow as a self-insuring employer, and the employees' rights to compensation and benefits; and

(h) The employer has either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the employer clearly indicates that payment will be honored by a financial institution in this state.

The administrator may waive the requirements of divisions (B)(1)(a) and (b) of this section and the requirement of division (B)(1)(e) of this section that the financial records, documents, and data be certified by a certified public accountant. The administrator shall adopt rules establishing the criteria that an employer shall meet in order for the administrator to waive the requirement of division (B)(1)(e) of this section. Such rules may require additional security of that employer pursuant to division (E) of section 4123.351 of the Revised Code.

The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, excluding its hospitals, that meets the requirements of division (B)(2) of this section.

(2) When considering the application of a public employer,

except for a board of county commissioners described in division 1634
(G) of section 4123.01 of the Revised Code, a board of a county 1635
hospital, or a publicly owned utility, the administrator shall 1636
verify that the public employer satisfies all of the following 1637
requirements as the requirements apply to that public employer: 1638

(a) For the two-year period preceding application under this 1639
section, the public employer has maintained an unvoted debt 1640
capacity equal to at least two times the amount of the current 1641
annual premium established by the administrator under this chapter 1642
for that public employer for the year immediately preceding the 1643
year in which the public employer makes application under this 1644
section. 1645

(b) For each of the two fiscal years preceding application 1646
under this section, the unreserved and undesignated year-end fund 1647
balance in the public employer's general fund is equal to at least 1648
five per cent of the public employer's general fund revenues for 1649
the fiscal year computed in accordance with generally accepted 1650
accounting principles. 1651

(c) For the five-year period preceding application under this 1652
section, the public employer, to the extent applicable, has 1653
complied fully with the continuing disclosure requirements 1654
established in rules adopted by the United States securities and 1655
exchange commission under 17 C.F.R. 240.15c 2-12. 1656

(d) For the five-year period preceding application under this 1657
section, the public employer has not had its local government fund 1658
distribution withheld on account of the public employer being 1659
indebted or otherwise obligated to the state. 1660

(e) For the five-year period preceding application under this 1661
section, the public employer has not been under a fiscal watch or 1662
fiscal emergency pursuant to section 118.023, 118.04, or 3316.03 1663
of the Revised Code. 1664

(f) For the public employer's fiscal year preceding 1665
application under this section, the public employer has obtained 1666
an annual financial audit as required under section 117.10 of the 1667
Revised Code, which has been released by the auditor of state 1668
within seven months after the end of the public employer's fiscal 1669
year. 1670

(g) On the date of application, the public employer holds a 1671
debt rating of Aa3 or higher according to Moody's investors 1672
service, inc., or a comparable rating by an independent rating 1673
agency similar to Moody's investors service, inc. 1674

(h) The public employer agrees to generate an annual 1675
accumulating book reserve in its financial statements reflecting 1676
an actuarially generated reserve adequate to pay projected claims 1677
under this chapter for the applicable period of time, as 1678
determined by the administrator. 1679

(i) For a public employer that is a hospital, the public 1680
employer shall submit audited financial statements showing the 1681
hospital's overall liquidity characteristics, and the 1682
administrator shall determine, on an individual basis, whether the 1683
public employer satisfies liquidity standards equivalent to the 1684
liquidity standards of other public employers. 1685

(j) Any additional criteria that the administrator adopts by 1686
rule pursuant to division (E) of this section. 1687

The administrator shall not approve the application of a 1688
public employer, except for a board of county commissioners 1689
described in division (G) of section 4123.01 of the Revised Code, 1690
a board of a county hospital, or publicly owned utility, who does 1691
not satisfy all of the requirements listed in division (B)(2) of 1692
this section. 1693

(C) A board of county commissioners described in division (G) 1694
of section 4123.01 of the Revised Code, as an employer, that will 1695

abide by the rules of the administrator and that may be of 1696
sufficient financial ability to render certain the payment of 1697
compensation to injured employees or the dependents of killed 1698
employees, and the furnishing of medical, surgical, nursing, and 1699
hospital attention and services and medicines, and funeral 1700
expenses, equal to or greater than is provided for in sections 1701
4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised 1702
Code, and that does not desire to insure the payment thereof or 1703
indemnify itself against loss sustained by the direct payment 1704
thereof, upon a finding of such facts by the administrator, may be 1705
granted the privilege to pay individually compensation, and 1706
furnish medical, surgical, nursing, and hospital services and 1707
attention and funeral expenses directly to injured employees or 1708
the dependents of killed employees, or to reimburse a health 1709
insurer or an employee who paid a health care provider for medical 1710
benefits provided by that health care provider, pursuant to 1711
section 4123.513 of the Revised Code, thereby being granted status 1712
as a self-insuring employer. The administrator may charge a board 1713
of county commissioners described in division (G) of section 1714
4123.01 of the Revised Code that applies for the status as a 1715
self-insuring employer a reasonable application fee to cover the 1716
bureau's costs in connection with processing and making a 1717
determination with respect to an application. All employers 1718
granted such status shall demonstrate sufficient financial and 1719
administrative ability to assure that all obligations under this 1720
section are promptly met. The administrator shall deny the 1721
privilege where the employer is unable to demonstrate the 1722
employer's ability to promptly meet all the obligations imposed on 1723
the employer by this section. The administrator shall consider, 1724
but is not limited to, the following factors, where applicable, in 1725
determining the employer's ability to meet all of the obligations 1726
imposed on the board as an employer by this section: 1727

(1) The board as an employer employs a minimum of five 1728

hundred employees in this state;	1729
(2) The board has operated in this state for a minimum of two years;	1730 1731
(3) Where the board previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;	1732 1733 1734
(4) The sufficiency of the board's assets located in this state to insure the board's solvency in paying compensation directly;	1735 1736 1737
(5) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the board's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.	1738 1739 1740 1741 1742
(6) The board's organizational plan for the administration of the workers' compensation law;	1743 1744
(7) The board's proposed plan to inform employees of the proposed self-insurance, the procedures the board will follow as a self-insuring employer, and the employees' rights to compensation and benefits;	1745 1746 1747 1748
(8) The board has either an account in a financial institution in this state, or if the board maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the board clearly indicates that payment will be honored by a financial institution in this state;	1749 1750 1751 1752 1753 1754
(9) The board shall provide the administrator a surety bond in an amount equal to one hundred twenty-five per cent of the projected losses as determined by the administrator.	1755 1756 1757
(D) The administrator shall require a surety bond from all	1758

self-insuring employers, issued pursuant to section 4123.351 of 1759
the Revised Code, that is sufficient to compel, or secure to 1760
injured employees, or to the dependents of employees killed, the 1761
payment of compensation and expenses and the reimbursement of 1762
health insurers and employees for the payment of medical benefits 1763
pursuant to section 4123.513 of the Revised Code, which shall in 1764
no event be less than that paid or furnished out of the state 1765
insurance fund in similar cases to injured employees or to 1766
dependents of killed employees whose employers contribute to the 1767
fund, except when an employee of the employer, who has suffered 1768
the loss of a hand, arm, foot, leg, or eye prior to the injury for 1769
which compensation is to be paid, and thereafter suffers the loss 1770
of any other of the members as the result of any injury sustained 1771
in the course of and arising out of the employee's employment, the 1772
compensation to be paid by the self-insuring employer is limited 1773
to the disability suffered in the subsequent injury, additional 1774
compensation, if any, to be paid by the bureau out of the surplus 1775
created by section 4123.34 of the Revised Code. 1776

(E) In addition to the requirements of this section, the 1777
administrator shall make and publish rules governing the manner of 1778
making application and the nature and extent of the proof required 1779
to justify a finding of fact by the administrator as to granting 1780
the status of a self-insuring employer, which rules shall be 1781
general in their application, one of which rules shall provide 1782
that all self-insuring employers shall pay into the state 1783
insurance fund such amounts as are required to be credited to the 1784
surplus fund in division (B) of section 4123.34 of the Revised 1785
Code. The administrator may adopt rules establishing requirements 1786
in addition to the requirements described in division (B)(2) of 1787
this section that a public employer shall meet in order to qualify 1788
for self-insuring status. 1789

Employers shall secure directly from the bureau central 1790

offices application forms upon which the bureau shall stamp a 1791
designating number. Prior to submission of an application, an 1792
employer shall make available to the bureau, and the bureau shall 1793
review, the information described in division (B)(1) of this 1794
section, and public employers shall make available, and the bureau 1795
shall review, the information necessary to verify whether the 1796
public employer meets the requirements listed in division (B)(2) 1797
of this section. An employer shall file the completed application 1798
forms with an application fee, which shall cover the costs of 1799
processing the application, as established by the administrator, 1800
by rule, with the bureau at least ninety days prior to the 1801
effective date of the employer's new status as a self-insuring 1802
employer. The application form is not deemed complete until all 1803
the required information is attached thereto. The bureau shall 1804
only accept applications that contain the required information. 1805

(F) The bureau shall review completed applications within a 1806
reasonable time. If the bureau determines to grant an employer the 1807
status as a self-insuring employer, the bureau shall issue a 1808
statement, containing its findings of fact, that is prepared by 1809
the bureau and signed by the administrator. If the bureau 1810
determines not to grant the status as a self-insuring employer, 1811
the bureau shall notify the employer of the determination and 1812
require the employer to continue to pay its full premium into the 1813
state insurance fund. The administrator also shall adopt rules 1814
establishing a minimum level of performance as a criterion for 1815
granting and maintaining the status as a self-insuring employer 1816
and fixing time limits beyond which failure of the self-insuring 1817
employer to provide for the necessary medical examinations and 1818
evaluations may not delay a decision on a claim. 1819

(G) The administrator shall adopt rules setting forth 1820
procedures for auditing the program of self-insuring employers. 1821
The bureau shall conduct the audit upon a random basis or whenever 1822

the bureau has grounds for believing that a self-insuring employer 1823
is not in full compliance with bureau rules or this chapter. 1824

The administrator shall monitor the programs conducted by 1825
self-insuring employers, to ensure compliance with bureau 1826
requirements and for that purpose, shall develop and issue to 1827
self-insuring employers standardized forms for use by the 1828
self-insuring employer in all aspects of the self-insuring 1829
employers' direct compensation program and for reporting of 1830
information to the bureau. 1831

The bureau shall receive and transmit to the self-insuring 1832
employer all complaints concerning any self-insuring employer. In 1833
the case of a complaint against a self-insuring employer, the 1834
administrator shall handle the complaint through the 1835
self-insurance division of the bureau. The bureau shall maintain a 1836
file by employer of all complaints received that relate to the 1837
employer. The bureau shall evaluate each complaint and take 1838
appropriate action. 1839

The administrator shall adopt as a rule a prohibition against 1840
any self-insuring employer from harassing, dismissing, or 1841
otherwise disciplining any employee making a complaint, which rule 1842
shall provide for a financial penalty to be levied by the 1843
administrator payable by the offending self-insuring employer. 1844

(H) For the purpose of making determinations as to whether to 1845
grant status as a self-insuring employer, the administrator may 1846
subscribe to and pay for a credit reporting service that offers 1847
financial and other business information about individual 1848
employers. The costs in connection with the bureau's subscription 1849
or individual reports from the service about an applicant may be 1850
included in the application fee charged employers under this 1851
section. 1852

(I) The administrator, notwithstanding other provisions of 1853

this chapter, may permit a self-insuring employer to resume 1854
payment of premiums to the state insurance fund with appropriate 1855
credit modifications to the employer's basic premium rate as such 1856
rate is determined pursuant to section 4123.29 of the Revised 1857
Code. 1858

(J) On the first day of July of each year, the administrator 1859
shall calculate separately each self-insuring employer's 1860
assessments for the safety and hygiene fund, administrative costs 1861
pursuant to section 4123.342 of the Revised Code, and for the 1862
portion of the surplus fund under division (B) of section 4123.34 1863
of the Revised Code that is not used for handicapped 1864
reimbursement, on the basis of the paid compensation attributable 1865
to the individual self-insuring employer according to the 1866
following calculation: 1867

(1) The total assessment against all self-insuring employers 1868
as a class for each fund and for the administrative costs for the 1869
year that the assessment is being made, as determined by the 1870
administrator, divided by the total amount of paid compensation 1871
for the previous calendar year attributable to all amenable 1872
self-insuring employers; 1873

(2) Multiply the quotient in division (J)(1) of this section 1874
by the total amount of paid compensation for the previous calendar 1875
year that is attributable to the individual self-insuring employer 1876
for whom the assessment is being determined. Each self-insuring 1877
employer shall pay the assessment that results from this 1878
calculation, unless the assessment resulting from this calculation 1879
falls below a minimum assessment, which minimum assessment the 1880
administrator shall determine on the first day of July of each 1881
year with the advice and consent of the workers' compensation 1882
oversight commission, in which event, the self-insuring employer 1883
shall pay the minimum assessment. 1884

In determining the total amount due for the total assessment 1885

against all self-insuring employers as a class for each fund and 1886
the administrative assessment, the administrator shall reduce 1887
proportionately the total for each fund and assessment by the 1888
amount of money in the self-insurance assessment fund as of the 1889
date of the computation of the assessment. 1890

The administrator shall calculate the assessment for the 1891
portion of the surplus fund under division (B) of section 4123.34 1892
of the Revised Code that is used for handicapped reimbursement in 1893
the same manner as set forth in divisions (J)(1) and (2) of this 1894
section except that the administrator shall calculate the total 1895
assessment for this portion of the surplus fund only on the basis 1896
of those self-insuring employers that retain participation in the 1897
handicapped reimbursement program and the individual self-insuring 1898
employer's proportion of paid compensation shall be calculated 1899
only for those self-insuring employers who retain participation in 1900
the handicapped reimbursement program. The administrator, as the 1901
administrator determines appropriate, may determine the total 1902
assessment for the handicapped portion of the surplus fund in 1903
accordance with sound actuarial principles. 1904

The administrator shall calculate the assessment for the 1905
portion of the surplus fund under division (B) of section 4123.34 1906
of the Revised Code that under division (D) of section 4121.66 of 1907
the Revised Code is used for rehabilitation costs in the same 1908
manner as set forth in divisions (J)(1) and (2) of this section, 1909
except that the administrator shall calculate the total assessment 1910
for this portion of the surplus fund only on the basis of those 1911
self-insuring employers who have not made the election to make 1912
payments directly under division (D) of section 4121.66 of the 1913
Revised Code and an individual self-insuring employer's proportion 1914
of paid compensation only for those self-insuring employers who 1915
have not made that election. 1916

The administrator shall calculate the assessment for the 1917

portion of the surplus fund under division (B) of section 4123.34 1918
of the Revised Code that is used for reimbursement to a 1919
self-insuring employer under division (H) of section 4123.512 of 1920
the Revised Code in the same manner as set forth in divisions 1921
(J)(1) and (2) of this section except that the administrator shall 1922
calculate the total assessment for this portion of the surplus 1923
fund only on the basis of those self-insuring employers that 1924
retain participation in reimbursement to the self-insuring 1925
employer under division (H) of section 4123.512 of the Revised 1926
Code and the individual self-insuring employer's proportion of 1927
paid compensation shall be calculated only for those self-insuring 1928
employers who retain participation in reimbursement to the 1929
self-insuring employer under division (H) of section 4123.512 of 1930
the Revised Code. 1931

An employer who no longer is a self-insuring employer in this 1932
state or who no longer is operating in this state, shall continue 1933
to pay assessments for administrative costs and for the portion of 1934
the surplus fund under division (B) of section 4123.34 of the 1935
Revised Code that is not used for handicapped reimbursement, based 1936
upon paid compensation attributable to claims that occurred while 1937
the employer was a self-insuring employer within this state. 1938

(K) There is hereby created in the state treasury the 1939
self-insurance assessment fund. All investment earnings of the 1940
fund shall be deposited in the fund. The administrator shall use 1941
the money in the self-insurance assessment fund only for 1942
administrative costs as specified in section 4123.341 of the 1943
Revised Code. 1944

(L) Every self-insuring employer shall certify, in affidavit 1945
form subject to the penalty for perjury, to the bureau the amount 1946
of the self-insuring employer's paid compensation for the previous 1947
calendar year. In reporting paid compensation paid for the 1948
previous year, a self-insuring employer shall exclude from the 1949

total amount of paid compensation any reimbursement the 1950
self-insuring employer receives in the previous calendar year from 1951
the surplus fund pursuant to section 4123.512 of the Revised Code 1952
for any paid compensation. The self-insuring employer also shall 1953
exclude from the paid compensation reported any amount recovered 1954
under section 4123.931 of the Revised Code and any amount that is 1955
determined not to have been payable to or on behalf of a claimant 1956
in any final administrative or judicial proceeding. The 1957
self-insuring employer shall exclude such amounts from the paid 1958
compensation reported in the reporting period subsequent to the 1959
date the determination is made. The administrator shall adopt 1960
rules, in accordance with Chapter 119. of the Revised Code, that 1961
provide for all of the following: 1962

(1) Establishing the date by which self-insuring employers 1963
must submit such information and the amount of the assessments 1964
provided for in division (J) of this section for employers who 1965
have been granted self-insuring status within the last calendar 1966
year; 1967

(2) If an employer fails to pay the assessment when due, the 1968
administrator may add a late fee penalty of not more than five 1969
hundred dollars to the assessment plus an additional penalty 1970
amount as follows: 1971

(a) For an assessment from sixty-one to ninety days past due, 1972
the prime interest rate, multiplied by the assessment due; 1973

(b) For an assessment from ninety-one to one hundred twenty 1974
days past due, the prime interest rate plus two per cent, 1975
multiplied by the assessment due; 1976

(c) For an assessment from one hundred twenty-one to one 1977
hundred fifty days past due, the prime interest rate plus four per 1978
cent, multiplied by the assessment due; 1979

(d) For an assessment from one hundred fifty-one to one 1980

hundred eighty days past due, the prime interest rate plus six per cent, multiplied by the assessment due;

(e) For an assessment from one hundred eighty-one to two hundred ten days past due, the prime interest rate plus eight per cent, multiplied by the assessment due;

(f) For each additional thirty-day period or portion thereof that an assessment remains past due after it has remained past due for more than two hundred ten days, the prime interest rate plus eight per cent, multiplied by the assessment due.

(3) An employer may appeal a late fee penalty and penalty assessment to the administrator.

For purposes of this division, "prime interest rate" means the average bank prime rate, and the administrator shall determine the prime interest rate in the same manner as a county auditor determines the average bank prime rate under section 929.02 of the Revised Code.

The administrator shall include any assessment and penalties that remain unpaid for previous assessment periods in the calculation and collection of any assessments due under this division or division (J) of this section.

(M) As used in this section, "paid compensation" means all amounts paid by a self-insuring employer for living maintenance benefits, all amounts for compensation paid pursuant to sections 4121.63, 4121.67, 4123.56, 4123.57, 4123.58, 4123.59, 4123.60, and 4123.64 of the Revised Code, all amounts paid as wages in lieu of such compensation, all amounts paid in lieu of such compensation under a nonoccupational accident and sickness program fully funded by the self-insuring employer, and all amounts paid by a self-insuring employer for a violation of a specific safety standard pursuant to Section 35 of Article II, Ohio Constitution and section 4121.47 of the Revised Code.

(N) Should any section of this chapter or Chapter 4121. of 2012
the Revised Code providing for self-insuring employers' 2013
assessments based upon compensation paid be declared 2014
unconstitutional by a final decision of any court, then that 2015
section of the Revised Code declared unconstitutional shall revert 2016
back to the section in existence prior to November 3, 1989, 2017
providing for assessments based upon payroll. 2018

(O) The administrator may grant a self-insuring employer the 2019
privilege to self-insure a construction project entered into by 2020
the self-insuring employer that is scheduled for completion within 2021
six years after the date the project begins, and the total cost of 2022
which is estimated to exceed one hundred million dollars or, for 2023
employers described in division (R) of this section, if the 2024
construction project is estimated to exceed twenty-five million 2025
dollars. The administrator may waive such cost and time criteria 2026
and grant a self-insuring employer the privilege to self-insure a 2027
construction project regardless of the time needed to complete the 2028
construction project and provided that the cost of the 2029
construction project is estimated to exceed fifty million dollars. 2030
A self-insuring employer who desires to self-insure a construction 2031
project shall submit to the administrator an application listing 2032
the dates the construction project is scheduled to begin and end, 2033
the estimated cost of the construction project, the contractors 2034
and subcontractors whose employees are to be self-insured by the 2035
self-insuring employer, the provisions of a safety program that is 2036
specifically designed for the construction project, and a 2037
statement as to whether a collective bargaining agreement 2038
governing the rights, duties, and obligations of each of the 2039
parties to the agreement with respect to the construction project 2040
exists between the self-insuring employer and a labor 2041
organization. 2042

A self-insuring employer may apply to self-insure the 2043

employees of either of the following: 2044

(1) All contractors and subcontractors who perform labor or 2045
work or provide materials for the construction project; 2046

(2) All contractors and, at the administrator's discretion, a 2047
substantial number of all the subcontractors who perform labor or 2048
work or provide materials for the construction project. 2049

Upon approval of the application, the administrator shall 2050
mail a certificate granting the privilege to self-insure the 2051
construction project to the self-insuring employer. The 2052
certificate shall contain the name of the self-insuring employer 2053
and the name, address, and telephone number of the self-insuring 2054
employer's representatives who are responsible for administering 2055
workers' compensation claims for the construction project. The 2056
self-insuring employer shall post the certificate in a conspicuous 2057
place at the site of the construction project. 2058

The administrator shall maintain a record of the contractors 2059
and subcontractors whose employees are covered under the 2060
certificate issued to the self-insured employer. A self-insuring 2061
employer immediately shall notify the administrator when any 2062
contractor or subcontractor is added or eliminated from inclusion 2063
under the certificate. 2064

Upon approval of the application, the self-insuring employer 2065
is responsible for the administration and payment of all claims 2066
under this chapter and Chapter 4121. of the Revised Code for the 2067
employees of the contractor and subcontractors covered under the 2068
certificate who receive injuries or are killed in the course of 2069
and arising out of employment on the construction project, or who 2070
contract an occupational disease in the course of employment on 2071
the construction project. For purposes of this chapter and Chapter 2072
4121. of the Revised Code, a claim that is administered and paid 2073
in accordance with this division is considered a claim against the 2074

self-insuring employer listed in the certificate. A contractor or 2075
subcontractor included under the certificate shall report to the 2076
self-insuring employer listed in the certificate, all claims that 2077
arise under this chapter and Chapter 4121. of the Revised Code in 2078
connection with the construction project for which the certificate 2079
is issued. 2080

A self-insuring employer who complies with this division is 2081
entitled to the protections provided under this chapter and 2082
Chapter 4121. of the Revised Code with respect to the employees of 2083
the contractors and subcontractors covered under a certificate 2084
issued under this division for death or injuries that arise out 2085
of, or death, injuries, or occupational diseases that arise in the 2086
course of, those employees' employment on that construction 2087
project, as if the employees were employees of the self-insuring 2088
employer, provided that the self-insuring employer also complies 2089
with this section. No employee of the contractors and 2090
subcontractors covered under a certificate issued under this 2091
division shall be considered the employee of the self-insuring 2092
employer listed in that certificate for any purposes other than 2093
this chapter and Chapter 4121. of the Revised Code. Nothing in 2094
this division gives a self-insuring employer authority to control 2095
the means, manner, or method of employment of the employees of the 2096
contractors and subcontractors covered under a certificate issued 2097
under this division. 2098

The contractors and subcontractors included under a 2099
certificate issued under this division are entitled to the 2100
protections provided under this chapter and Chapter 4121. of the 2101
Revised Code with respect to the contractor's or subcontractor's 2102
employees who are employed on the construction project which is 2103
the subject of the certificate, for death or injuries that arise 2104
out of, or death, injuries, or occupational diseases that arise in 2105
the course of, those employees' employment on that construction 2106

project. 2107

The contractors and subcontractors included under a 2108
certificate issued under this division shall identify in their 2109
payroll records the employees who are considered the employees of 2110
the self-insuring employer listed in that certificate for purposes 2111
of this chapter and Chapter 4121. of the Revised Code, and the 2112
amount that those employees earned for employment on the 2113
construction project that is the subject of that certificate. 2114
Notwithstanding any provision to the contrary under this chapter 2115
and Chapter 4121. of the Revised Code, the administrator shall 2116
exclude the payroll that is reported for employees who are 2117
considered the employees of the self-insuring employer listed in 2118
that certificate, and that the employees earned for employment on 2119
the construction project that is the subject of that certificate, 2120
when determining those contractors' or subcontractors' premiums or 2121
assessments required under this chapter and Chapter 4121. of the 2122
Revised Code. A self-insuring employer issued a certificate under 2123
this division shall include in the amount of paid compensation it 2124
reports pursuant to division (L) of this section, the amount of 2125
paid compensation the self-insuring employer paid pursuant to this 2126
division for the previous calendar year. 2127

Nothing in this division shall be construed as altering the 2128
rights of employees under this chapter and Chapter 4121. of the 2129
Revised Code as those rights existed prior to September 17, 1996. 2130
Nothing in this division shall be construed as altering the rights 2131
devolved under sections 2305.31 and 4123.82 of the Revised Code as 2132
those rights existed prior to September 17, 1996. 2133

As used in this division, "privilege to self-insure a 2134
construction project" means privilege to pay individually 2135
compensation, and to furnish medical, surgical, nursing, and 2136
hospital services and attention and funeral expenses directly to 2137
injured employees or the dependents of killed employees or to 2138

reimburse a health insurer or an employee who paid a health care 2139
provider for medical benefits provided by that health care 2140
provider, pursuant to section 4123.513 of the Revised Code. 2141

(P) A self-insuring employer whose application is granted 2142
under division (O) of this section shall designate a safety 2143
professional to be responsible for the administration and 2144
enforcement of the safety program that is specifically designed 2145
for the construction project that is the subject of the 2146
application. 2147

A self-insuring employer whose application is granted under 2148
division (O) of this section shall employ an ombudsperson for the 2149
construction project that is the subject of the application. The 2150
ombudsperson shall have experience in workers' compensation or the 2151
construction industry, or both. The ombudsperson shall perform all 2152
of the following duties: 2153

(1) Communicate with and provide information to employees who 2154
are injured in the course of, or whose injury arises out of 2155
employment on the construction project, or who contract an 2156
occupational disease in the course of employment on the 2157
construction project; 2158

(2) Investigate the status of a claim upon the request of an 2159
employee to do so; 2160

(3) Provide information to claimants, third party 2161
administrators, employers, and other persons to assist those 2162
persons in protecting their rights under this chapter and Chapter 2163
4121. of the Revised Code. 2164

A self-insuring employer whose application is granted under 2165
division (O) of this section shall post the name of the safety 2166
professional and the ombudsperson and instructions for contacting 2167
the safety professional and the ombudsperson in a conspicuous 2168
place at the site of the construction project. 2169

(Q) The administrator may consider all of the following when 2170
deciding whether to grant a self-insuring employer the privilege 2171
to self-insure a construction project as provided under division 2172
(O) of this section: 2173

(1) Whether the self-insuring employer has an organizational 2174
plan for the administration of the workers' compensation law; 2175

(2) Whether the safety program that is specifically designed 2176
for the construction project provides for the safety of employees 2177
employed on the construction project, is applicable to all 2178
contractors and subcontractors who perform labor or work or 2179
provide materials for the construction project, and has as a 2180
component, a safety training program that complies with standards 2181
adopted pursuant to the "Occupational Safety and Health Act of 2182
1970," 84 Stat. 1590, 29 U.S.C.A. 651, and provides for continuing 2183
management and employee involvement; 2184

(3) Whether granting the privilege to self-insure the 2185
construction project will reduce the costs of the construction 2186
project; 2187

(4) Whether the self-insuring employer has employed an 2188
ombudsperson as required under division (P) of this section; 2189

(5) Whether the self-insuring employer has sufficient surety 2190
to secure the payment of claims for which the self-insuring 2191
employer would be responsible pursuant to the granting of the 2192
privilege to self-insure a construction project under division (O) 2193
of this section. 2194

(R) As used in divisions (O), (P), and (Q), "self-insuring 2195
employer" includes the following employers, whether or not they 2196
have been granted the status of being a self-insuring employer 2197
under division (B) of this section: 2198

(1) A state institution of higher education; 2199

(2) A school district;	2200
(3) A county school financing district;	2201
(4) An educational service center;	2202
(5) A community school established under Chapter 3314. of the Revised Code.	2203 2204
(S) As used in this section:	2205
(1) "Unvoted debt capacity" means the amount of money that a public employer may borrow without voter approval of a tax levy;	2206 2207
(2) "State institution of higher education" means the state universities listed in section 3345.011 of the Revised Code, community colleges created pursuant to Chapter 3354. of the Revised Code, university branches created pursuant to Chapter 3355. of the Revised Code, technical colleges created pursuant to Chapter 3357. of the Revised Code, and state community colleges created pursuant to Chapter 3358. of the Revised Code.	2208 2209 2210 2211 2212 2213 2214
Sec. 4123.511. (A) <u>Within If a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code and the employee has health insurance, the health care provider shall submit a claim to the employee's health insurer and shall include a statement with the bill that the employee's injury or occupational disease may be compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code. Within three days after receiving such a claim from a health care provider, the health insurer shall file a claim with the bureau of workers' compensation regarding the alleged injury or occupational disease. If a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under this chapter or Chapter 4121., 4127., or 4131.</u>	2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229

of the Revised Code and the employee does not have health 2230
insurance, the health care provider, employee, or employer shall 2231
file a claim with the bureau regarding the alleged injury or 2232
occupational disease. 2233

Within seven days after receipt of any claim under this 2234
chapter, the bureau ~~of workers' compensation~~ shall notify the 2235
claimant and the employer of the receipt of the 2236
claim and of the facts alleged therein. If the bureau receives 2237
from a person other than the claimant written or facsimile 2238
information or information communicated verbally over the 2239
telephone indicating that an injury or occupational disease has 2240
occurred or been contracted which may be compensable under this 2241
chapter, the bureau shall notify the employee and the employer of 2242
the information. If the information is provided verbally over the 2243
telephone, the person providing the information shall provide 2244
written verification of the information to the bureau according to 2245
division (E) of section 4123.84 of the Revised Code. The receipt 2246
of the information in writing or facsimile, or if initially by 2247
telephone, the subsequent written verification, and the notice by 2248
the bureau shall be considered an application for compensation 2249
under section 4123.84 or 4123.85 of the Revised Code, provided 2250
that the conditions of division (E) of section 4123.84 of the 2251
Revised Code apply to information provided verbally over the 2252
telephone. Upon receipt of a claim, the bureau shall advise the 2253
claimant of the claim number assigned and the claimant's right to 2254
representation in the processing of a claim or to elect no 2255
representation. If the bureau determines that a claim is 2256
determined to be a compensable lost-time claim, the bureau shall 2257
notify the claimant and the employer of the availability of 2258
rehabilitation services. No bureau or industrial commission 2259
employee shall directly or indirectly convey any information in 2260
derogation of this right. This section shall in no way abrogate 2261
the bureau's responsibility to aid and assist a claimant in the 2262

filing of a claim and to advise the claimant of the claimant's 2263
rights under the law. 2264

The administrator of workers' compensation shall assign all 2265
claims and investigations to the bureau service office from which 2266
investigation and determination may be made most expeditiously. 2267

The bureau shall investigate the facts concerning an injury 2268
or occupational disease and ascertain such facts in whatever 2269
manner is most appropriate and may obtain statements of the 2270
employee, employer, attending physician, and witnesses in whatever 2271
manner is most appropriate. 2272

The administrator of workers' compensation, with the advice 2273
and consent of the workers' compensation oversight commission, may 2274
adopt rules that identify specified medical conditions that have a 2275
historical record of being allowed whenever included in a claim. 2276
The administrator may grant immediate allowance of any medical 2277
condition identified in those rules upon the filing of a claim 2278
involving that medical condition and may make immediate payment of 2279
medical bills for any medical condition identified in those rules 2280
that is included in a claim. If an employer contests the allowance 2281
of a claim involving any medical condition identified in those 2282
rules, and the claim is disallowed, payment for the medical 2283
condition included in that claim shall be charged to and paid from 2284
the surplus fund created under section 4123.34 of the Revised 2285
Code. 2286

(B)(1) Except as provided in division (B)(2) of this section, 2287
in claims other than those in which the employer is a 2288
self-insuring employer, if the administrator determines under 2289
division (A) of this section that a claimant is or is not entitled 2290
to an award of compensation or benefits, the administrator shall 2291
issue an order no later than twenty-eight days after the sending 2292
of the notice under division (A) of this section, granting or 2293
denying the payment of the compensation or benefits, or both as is 2294

appropriate to the claimant. Notwithstanding the time limitation 2295
specified in this division for the issuance of an order, if a 2296
medical examination of the claimant is required by statute, the 2297
administrator promptly shall schedule the claimant for that 2298
examination and shall issue an order no later than twenty-eight 2299
days after receipt of the report of the examination. The 2300
administrator shall notify the claimant and the employer of the 2301
claimant and their respective representatives in writing of the 2302
nature of the order and the amounts of compensation and benefit 2303
payments involved. The employer or claimant may appeal the order 2304
pursuant to division (C) of this section within fourteen days 2305
after the date of the receipt of the order. The employer and 2306
claimant may waive, in writing, their rights to an appeal under 2307
this division. 2308

(2) Notwithstanding the time limitation specified in division 2309
(B)(1) of this section for the issuance of an order, if the 2310
employer certifies a claim for payment of compensation or 2311
benefits, or both, to a claimant, and the administrator has 2312
completed the investigation of the claim, the payment of benefits 2313
or compensation, or both, as is appropriate, shall commence upon 2314
the later of the date of the certification or completion of the 2315
investigation and issuance of the order by the administrator, 2316
provided that the administrator shall issue the order no later 2317
than the time limitation specified in division (B)(1) of this 2318
section. 2319

(3) If an appeal is made under division (B)(1) or (2) of this 2320
section, the administrator shall forward the claim file to the 2321
appropriate district hearing officer within seven days of the 2322
appeal. In contested claims other than state fund claims, the 2323
administrator shall forward the claim within seven days of the 2324
administrator's receipt of the claim to the commission, which 2325
shall refer the claim to an appropriate district hearing officer 2326

for a hearing in accordance with division (C) of this section. 2327

(C) If an employer or claimant timely appeals the order of 2328
the administrator issued under division (B) of this section or in 2329
the case of other contested claims other than state fund claims, 2330
the commission shall refer the claim to an appropriate district 2331
hearing officer according to rules the commission adopts under 2332
section 4121.36 of the Revised Code. The district hearing officer 2333
shall notify the parties and their respective representatives of 2334
the time and place of the hearing. 2335

The district hearing officer shall hold a hearing on a 2336
disputed issue or claim within forty-five days after the filing of 2337
the appeal under this division and issue a decision within seven 2338
days after holding the hearing. The district hearing officer shall 2339
notify the parties and their respective representatives in writing 2340
of the order. Any party may appeal an order issued under this 2341
division pursuant to division (D) of this section within fourteen 2342
days after receipt of the order under this division. 2343

(D) Upon the timely filing of an appeal of the order of the 2344
district hearing officer issued under division (C) of this 2345
section, the commission shall refer the claim file to an 2346
appropriate staff hearing officer according to its rules adopted 2347
under section 4121.36 of the Revised Code. The staff hearing 2348
officer shall hold a hearing within forty-five days after the 2349
filing of an appeal under this division and issue a decision 2350
within seven days after holding the hearing under this division. 2351
The staff hearing officer shall notify the parties and their 2352
respective representatives in writing of the staff hearing 2353
officer's order. Any party may appeal an order issued under this 2354
division pursuant to division (E) of this section within fourteen 2355
days after receipt of the order under this division. 2356

(E) Upon the filing of a timely appeal of the order of the 2357
staff hearing officer issued under division (D) of this section, 2358

the commission or a designated staff hearing officer, on behalf of 2359
the commission, shall determine whether the commission will hear 2360
the appeal. If the commission or the designated staff hearing 2361
officer decides to hear the appeal, the commission or the 2362
designated staff hearing officer shall notify the parties and 2363
their respective representatives in writing of the time and place 2364
of the hearing. The commission shall hold the hearing within 2365
forty-five days after the filing of the notice of appeal and, 2366
within seven days after the conclusion of the hearing, the 2367
commission shall issue its order affirming, modifying, or 2368
reversing the order issued under division (D) of this section. The 2369
commission shall notify the parties and their respective 2370
representatives in writing of the order. If the commission or the 2371
designated staff hearing officer determines not to hear the 2372
appeal, within fourteen days after the filing of the notice of 2373
appeal, the commission or the designated staff hearing officer 2374
shall issue an order to that effect and notify the parties and 2375
their respective representatives in writing of that order. 2376

Except as otherwise provided in this chapter and Chapters 2377
4121., 4127., and 4131. of the Revised Code, any party may appeal 2378
an order issued under this division to the court pursuant to 2379
section 4123.512 of the Revised Code within sixty days after 2380
receipt of the order, subject to the limitations contained in that 2381
section. 2382

(F) Every notice of an appeal from an order issued under 2383
divisions (B), (C), (D), and (E) of this section shall state the 2384
names of the claimant and employer, the number of the claim, the 2385
date of the decision appealed from, and the fact that the 2386
appellant appeals therefrom. 2387

(G) All of the following apply to the proceedings under 2388
divisions (C), (D), and (E) of this section: 2389

(1) The parties shall proceed promptly and without 2390

continuances except for good cause; 2391

(2) The parties, in good faith, shall engage in the free 2392
exchange of information relevant to the claim prior to the conduct 2393
of a hearing according to the rules the commission adopts under 2394
section 4121.36 of the Revised Code; 2395

(3) The administrator is a party and may appear and 2396
participate at all administrative proceedings on behalf of the 2397
state insurance fund. However, in cases in which the employer is 2398
represented, the administrator shall neither present arguments nor 2399
introduce testimony that is cumulative to that presented or 2400
introduced by the employer or the employer's representative. The 2401
administrator may file an appeal under this section on behalf of 2402
the state insurance fund; however, except in cases arising under 2403
section 4123.343 of the Revised Code, the administrator only may 2404
appeal questions of law or issues of fraud when the employer 2405
appears in person or by representative. 2406

(H) Except as provided in section 4121.63 of the Revised Code 2407
and division (J) of this section, payments of compensation to a 2408
claimant or on behalf of a claimant as a result of any order 2409
issued under this chapter shall commence upon the earlier of the 2410
following: 2411

(1) Fourteen days after the date the administrator issues an 2412
order under division (B) of this section, unless that order is 2413
appealed; 2414

(2) The date when the employer has waived the right to appeal 2415
a decision issued under division (B) of this section; 2416

(3) If no appeal of an order has been filed under this 2417
section or to a court under section 4123.512 of the Revised Code, 2418
the expiration of the time limitations for the filing of an appeal 2419
of an order; 2420

(4) The date of receipt by the employer of an order of a 2421

district hearing officer, a staff hearing officer, or the 2422
industrial commission issued under division (C), (D), or (E) of 2423
this section. 2424

(I) No medical benefits payable under this chapter or Chapter 2425
4121., 4127., or 4131. of the Revised Code are payable until the 2426
earlier of the following: 2427

(1) The date of the issuance of the staff hearing officer's 2428
order under division (D) of this section; 2429

(2) The date of the final administrative or judicial 2430
determination. 2431

(J) Upon the final administrative or judicial determination 2432
under this section or section 4123.512 of the Revised Code of an 2433
appeal of an order to pay compensation, if a claimant is found to 2434
have received compensation pursuant to a prior order which is 2435
reversed upon subsequent appeal, the claimant's employer, if a 2436
self-insuring employer, or the bureau, shall withhold from any 2437
amount to which the claimant becomes entitled pursuant to any 2438
claim, past, present, or future, under Chapter 4121., 4123., 2439
4127., or 4131. of the Revised Code, the amount of previously paid 2440
compensation to the claimant which, due to reversal upon appeal, 2441
the claimant is not entitled, pursuant to the following criteria: 2442

(1) No withholding for the first twelve weeks of temporary 2443
total disability compensation pursuant to section 4123.56 of the 2444
Revised Code shall be made; 2445

(2) Forty per cent of all awards of compensation paid 2446
pursuant to sections 4123.56 and 4123.57 of the Revised Code, 2447
until the amount overpaid is refunded; 2448

(3) Twenty-five per cent of any compensation paid pursuant to 2449
section 4123.58 of the Revised Code until the amount overpaid is 2450
refunded; 2451

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld.

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission.

(K) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time.

(L) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section.

(M) No person who is not an employee of the bureau or commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession.

(N) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial

commission and hearing officers of the commission may waive the 2483
time frame within which claims and appeals of claims set forth in 2484
this section must be filed upon a finding that the applicant was 2485
unable to comply with a filing deadline due to an emergency or a 2486
disaster. 2487

As used in this division: 2488

(1) "Emergency" means any occasion or instance for which the 2489
governor of Ohio or the president of the United States publicly 2490
declares an emergency and orders state or federal assistance to 2491
save lives and protect property, the public health and safety, or 2492
to lessen or avert the threat of a catastrophe. 2493

(2) "Disaster" means any natural catastrophe or fire, flood, 2494
or explosion, regardless of the cause, that causes damage of 2495
sufficient magnitude that the governor of Ohio or the president of 2496
the United States, through a public declaration, orders state or 2497
federal assistance to alleviate damage, loss, hardship, or 2498
suffering that results from the occurrence. 2499

Sec. 4123.512. (A) The claimant or the employer may appeal an 2500
order of the industrial commission made under division (E) of 2501
section 4123.511 of the Revised Code in any injury or occupational 2502
disease case, other than a decision as to the extent of disability 2503
to the court of common pleas of the county in which the injury was 2504
inflicted or in which the contract of employment was made if the 2505
injury occurred outside the state, or in which the contract of 2506
employment was made if the exposure occurred outside the state. If 2507
no common pleas court has jurisdiction for the purposes of an 2508
appeal by the use of the jurisdictional requirements described in 2509
this division, the appellant may use the venue provisions in the 2510
Rules of Civil Procedure to vest jurisdiction in a court. If the 2511
claim is for an occupational disease, the appeal shall be to the 2512
court of common pleas of the county in which the exposure which 2513

caused the disease occurred. Like appeal may be taken from an 2514
order of a staff hearing officer made under division (D) of 2515
section 4123.511 of the Revised Code from which the commission has 2516
refused to hear an appeal. The appellant shall file the notice of 2517
appeal with a court of common pleas within sixty days after the 2518
date of the receipt of the order appealed from or the date of 2519
receipt of the order of the commission refusing to hear an appeal 2520
of a staff hearing officer's decision under division (D) of 2521
section 4123.511 of the Revised Code. The filing of the notice of 2522
the appeal with the court is the only act required to perfect the 2523
appeal. 2524

If an action has been commenced in a court of a county other 2525
than a court of a county having jurisdiction over the action, the 2526
court, upon notice by any party or upon its own motion, shall 2527
transfer the action to a court of a county having jurisdiction. 2528

Notwithstanding anything to the contrary in this section, if 2529
the commission determines under section 4123.522 of the Revised 2530
Code that an employee, employer, or their respective 2531
representatives have not received written notice of an order or 2532
decision which is appealable to a court under this section and 2533
which grants relief pursuant to section 4123.522 of the Revised 2534
Code, the party granted the relief has sixty days from receipt of 2535
the order under section 4123.522 of the Revised Code to file a 2536
notice of appeal under this section. 2537

(B) The notice of appeal shall state the names of the 2538
claimant and the employer, the number of the claim, the date of 2539
the order appealed from, and the fact that the appellant appeals 2540
therefrom. 2541

The administrator of workers' compensation, the claimant, and 2542
the employer shall be parties to the appeal and the court, upon 2543
the application of the commission, shall make the commission a 2544
party. The party filing the appeal shall serve a copy of the 2545

notice of appeal on the administrator at the central office of the 2546
bureau of workers' compensation in Columbus. The administrator 2547
shall notify the employer that if the employer fails to become an 2548
active party to the appeal, then the administrator may act on 2549
behalf of the employer and the results of the appeal could have an 2550
adverse effect upon the employer's premium rates. 2551

(C) The attorney general or one or more of the attorney 2552
general's assistants or special counsel designated by the attorney 2553
general shall represent the administrator and the commission. In 2554
the event the attorney general or the attorney general's 2555
designated assistants or special counsel are absent, the 2556
administrator or the commission shall select one or more of the 2557
attorneys in the employ of the administrator or the commission as 2558
the administrator's attorney or the commission's attorney in the 2559
appeal. Any attorney so employed shall continue the representation 2560
during the entire period of the appeal and in all hearings thereof 2561
except where the continued representation becomes impractical. 2562

(D) Upon receipt of notice of appeal, the clerk of courts 2563
shall provide notice to all parties who are appellees and to the 2564
commission. 2565

The claimant shall, within thirty days after the filing of 2566
the notice of appeal, file a petition containing a statement of 2567
facts in ordinary and concise language showing a cause of action 2568
to participate or to continue to participate in the fund and 2569
setting forth the basis for the jurisdiction of the court over the 2570
action. Further pleadings shall be had in accordance with the 2571
Rules of Civil Procedure, provided that service of summons on such 2572
petition shall not be required and provided that the claimant may 2573
not dismiss the complaint without the employer's consent if the 2574
employer is the party that filed the notice of appeal to court 2575
pursuant to this section. The clerk of the court shall, upon 2576
receipt thereof, transmit by certified mail a copy thereof to each 2577

party named in the notice of appeal other than the claimant. Any 2578
party may file with the clerk prior to the trial of the action a 2579
deposition of any physician taken in accordance with the 2580
provisions of the Revised Code, which deposition may be read in 2581
the trial of the action even though the physician is a resident of 2582
or subject to service in the county in which the trial is had. The 2583
bureau of workers' compensation shall pay the cost of the 2584
stenographic deposition filed in court and of copies of the 2585
stenographic deposition for each party from the surplus fund and 2586
charge the costs thereof against the unsuccessful party if the 2587
claimant's right to participate or continue to participate is 2588
finally sustained or established in the appeal. In the event the 2589
deposition is taken and filed, the physician whose deposition is 2590
taken is not required to respond to any subpoena issued in the 2591
trial of the action. The court, or the jury under the instructions 2592
of the court, if a jury is demanded, shall determine the right of 2593
the claimant to participate or to continue to participate in the 2594
fund upon the evidence adduced at the hearing of the action. 2595

(E) The court shall certify its decision to the commission 2596
and the certificate shall be entered in the records of the court. 2597
Appeals from the judgment are governed by the law applicable to 2598
the appeal of civil actions. 2599

(F) The cost of any legal proceedings authorized by this 2600
section, including an attorney's fee to the claimant's attorney to 2601
be fixed by the trial judge, based upon the effort expended, in 2602
the event the claimant's right to participate or to continue to 2603
participate in the fund is established upon the final 2604
determination of an appeal, shall be taxed against the employer or 2605
the commission if the commission or the administrator rather than 2606
the employer contested the right of the claimant to participate in 2607
the fund. The attorney's fee shall not exceed forty-two hundred 2608
dollars. 2609

(G) If the finding of the court or the verdict of the jury is 2610
in favor of the claimant's right to participate in the fund, the 2611
commission and the administrator shall thereafter proceed in the 2612
matter of the claim as if the judgment were the decision of the 2613
commission, subject to the power of modification provided by 2614
section 4123.52 of the Revised Code. 2615

(H) An appeal from an order issued under division (E) of 2616
section 4123.511 of the Revised Code or any action filed in court 2617
in a case in which an award of compensation has been made shall 2618
not stay the payment of compensation under the award or payment of 2619
compensation for subsequent periods of total disability during the 2620
pendency of the appeal. If, in a final administrative or judicial 2621
action, it is determined that payments of compensation or 2622
benefits, or both, made to or on behalf of a claimant should not 2623
have been made, the amount thereof shall be charged to the surplus 2624
fund under division (B) of section 4123.34 of the Revised Code. In 2625
the event the employer is a state risk, the amount shall not be 2626
charged to the employer's experience. In the event the employer is 2627
a self-insuring employer, the self-insuring employer shall deduct 2628
the amount from the paid compensation the self-insuring employer 2629
reports to the administrator under division (L) of section 4123.35 2630
of the Revised Code. 2631

A self-insuring employer may elect to pay compensation and 2632
benefits under this section directly to or on behalf of an 2633
employee or an employee's dependents by filing an application with 2634
the bureau of workers' compensation not more than one hundred 2635
eighty days and not less than ninety days before the first day of 2636
the employer's next six-month coverage period. If the 2637
self-insuring employer timely files the application, the 2638
application is effective on the first day of the employer's next 2639
six-month coverage period, provided that the administrator shall 2640
compute the employer's assessment for the surplus fund due with 2641

respect to the period during which that application was filed 2642
without regard to the filing of the application. On and after the 2643
effective date of the employer's election, the self-insuring 2644
employer shall pay directly to or on behalf of an employee or to 2645
an employee's dependents compensation and benefits under this 2646
section regardless of the date of the injury or occupational 2647
disease, and the employer shall receive no money or credits from 2648
the surplus fund on account of those payments and shall not be 2649
required to pay any amounts into the surplus fund on account of 2650
this section. The election made under this division is 2651
irrevocable. 2652

All actions and proceedings under this section which are the 2653
subject of an appeal to the court of common pleas or the court of 2654
appeals shall be preferred over all other civil actions except 2655
election causes, irrespective of position on the calendar. 2656

This section applies to all decisions of the commission or 2657
the administrator on November 2, 1959, and all claims filed 2658
thereafter are governed by sections 4123.511 and 4123.512 of the 2659
Revised Code. 2660

Any action pending in common pleas court or any other court 2661
on January 1, 1986, under this section is governed by former 2662
sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 2663
4123.522 of the Revised Code. 2664

Sec. 4123.513. (A) During the time period in which an 2665
employee's workers' compensation claim is pending under section 2666
4123.511 or 4123.512 of the Revised Code, an employee who suffers 2667
an injury or who contracts an occupational disease shall use the 2668
employee's health insurance to pay the medical bills for the 2669
services provided to care for the injury or occupational disease. 2670
If the employee does not have health insurance, the employee may 2671
pay those medical bills directly. An employee may use the 2672

employee's health savings account or medical savings account to 2673
pay any medical bills accrued in the claim. 2674

(1) If a health care provider provides services to an 2675
employee for an injury or occupational disease and that employee 2676
has health insurance, the health care provider shall submit all 2677
medical bills that accrue as a result of that injury or 2678
occupational disease to the employee's health insurer for 2679
reimbursement until the health care provider receives the notice 2680
described in division (B)(2) of this section. Notwithstanding 2681
section 3901.71 of the Revised Code, the employee's health insurer 2682
shall pay all medical bills that the health insurer receives for 2683
that injury or occupational disease in accordance with the 2684
employee's health insurance policy, contract, or agreement unless 2685
the health insurer receives the notice described in division 2686
(B)(2) of this section. The health insurer shall maintain copies 2687
of all medical bills the health insurer pays for treatment of that 2688
injury or occupational disease. 2689

A health care provider may bill an employee directly for any 2690
services rendered for that employee's injury or occupational 2691
disease that are not covered by the employee's health insurance 2692
policy, contract, or agreement. A health care provider may charge 2693
or assess the employee a copayment in accordance with the 2694
provisions of the employee's health insurance policy, contract, or 2695
agreement. If the employee pays any medical bill, copayments, or 2696
any part of a deductible, the employee shall maintain copies of 2697
all those medical bills, copayments, or parts of a deductible the 2698
employee paid. 2699

(2) If a health care provider provides services to an 2700
employee for an injury or occupational disease and that employee 2701
does not have health insurance, the health care provider may bill 2702
the employee directly for all services rendered for that 2703
employee's injury or occupational disease. The employee shall 2704

maintain copies of all medical bills the employee paid for that 2705
injury or occupational disease. 2706

(3) If an employee uses funds from a health savings account 2707
or a medical savings account to pay for any medical bills for 2708
services rendered for the employee's injury or occupational 2709
disease, the employee shall maintain copies of those bills and 2710
indicate on those copies that the employee used funds from a 2711
health savings account or medical savings account to pay for those 2712
bills. 2713

(B) Within five days after a final determination is made 2714
concerning an employee's eligibility to receive compensation and 2715
benefits under this chapter or Chapter 4121., 4127., or 4131. of 2716
the Revised Code for the employee's injury or occupational disease 2717
pursuant to section 4123.511 or 4123.512 of the Revised Code, the 2718
administrator of workers' compensation shall send to the employer, 2719
the employee, the employee's health insurer, if applicable, and 2720
the employee's health care provider the appropriate written notice 2721
described in division (B)(1) or (2) of this section. 2722

(1) If a final determination is made that an employee is not 2723
eligible to receive compensation and benefits under this chapter 2724
or Chapter 4121., 4127., or 4131. of the Revised Code for that 2725
injury or occupational disease, the administrator shall include 2726
all of the following statements in a written notice: 2727

(a) The employee is ineligible to receive workers' 2728
compensation and benefits for the employee's injury or 2729
occupational disease. 2730

(b) The health care provider shall continue billing the 2731
health insurer or employee, as applicable, for services rendered 2732
by that health care provider to treat the employee's injury or 2733
occupational disease. 2734

(c) If a health insurer is covering the service rendered by a 2735

health care provider for the employee's injury or occupational 2736
disease, the health insurer shall continue providing coverage in 2737
accordance with the provisions of the employee's health insurance 2738
policy, contract, or agreement. 2739

(2) If a final determination is made that the employee is 2740
eligible to receive compensation and benefits under this chapter 2741
or Chapter 4121., 4127., or 4131. of the Revised Code for the 2742
employee's injury or occupational disease, the administrator shall 2743
include all of the following statements in a written notice: 2744

(a) The employee is eligible to receive workers' compensation 2745
and benefits for the employee's injury or occupational disease. 2746

(b) The health care provider shall cease billing the 2747
employee's health insurer or employee and shall submit all bills 2748
for that employee's injury or occupational disease with a date of 2749
service on or after the date that the final determination is made, 2750
to the administrator, or if the employee's employer is a 2751
self-insuring employer, to the employer, for payment. 2752

(c) If a health insurer paid a health care provider for 2753
services rendered for that claim prior to the date that the final 2754
determination is made, the health insurer shall submit copies of 2755
all invoices paid by the health insurer for that claim to the 2756
administrator, or if the employee's employer is a self-insuring 2757
employer, to the employer, and include the employee's claim number 2758
on each copy of an invoice that the health insurer submits. 2759

(d) If an employee paid any medical bills, copayments, or 2760
part of a deductible, or used a health savings account or medical 2761
savings account to pay a bill, the employee shall submit copies of 2762
all bills paid to the administrator or, if the employee's employer 2763
is a self-insuring employer, to the employer, and shall include 2764
the employee's claim number on each copy of a bill that the 2765
employee submits. 2766

(C) Except as provided in division (D) of this section, upon receipt of the copies of medical bills paid by a health insurer or employee, the administrator, or the employee's employer, if the employee's employer is a self-insuring employer, shall reimburse the health insurer or the employee for any medical bill the health insurer or employee paid for that claim on the condition that the services rendered for that medical bill are compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code. The administrator or self-insuring employer, as appropriate, also shall reimburse an employee for any copayments and any part of a deductible that the employee paid for that compensable claim.

(D) Upon receipt of a copy of a medical bill from an employee that indicates that the employee used funds from a health savings account or medical savings account to pay that bill, the administrator or self-insuring employer, as appropriate, shall send the reimbursement for that bill to the trustee or custodian of the health savings account or medical savings account, who shall deposit the reimbursement in the employee's health savings account or medical savings account, as applicable, on behalf of the employee. The administrator or self-insuring employer shall reimburse only those bills that are compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(E) Beginning on the date that a final determination is made that an employee is eligible to receive compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code, the administrator or self-insuring employer, as appropriate, shall commence payment of the medical bills for that employee's claim.

(F) As used in this section:

(1) "Final determination" means the later of the date that any of the following occur:

(a) The decision by the administrator, the industrial commission, or a court allowing compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code to an employee or an employee's dependents from which there is no further right to reconsideration or appeal that would require the bureau of workers' compensation or a self-insuring employer to withhold the payment of medical benefits; 2798
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(b) The rights to reconsideration or appeal have expired without the employee or employer applying for reconsideration or appeal; 2805
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(c) The application for reconsideration or appeal is withdrawn. 2808
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(2) "Health savings account" means a health insurance plan that complies with the provisions of section 223 of the "Internal Revenue Code of 1986," 26 U.S.C. 223, as amended. 2810
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(3) "Medical savings account" means a health insurance plan that complies with the provisions of section 220 of the "Internal Revenue Code of 1986," 26 U.S.C. 220, as amended. 2813
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Sec. 4123.82. (A) All contracts and agreements are void which 2816
undertake to indemnify or insure an employer against loss or 2817
liability for the payment of compensation to workers or their 2818
dependents for death, injury, or occupational disease occasioned 2819
in the course of the workers' employment, or which provide that 2820
the insurer shall pay the compensation, or which indemnify the 2821
employer against damages when the injury, disease, or death arises 2822
from the failure to comply with any lawful requirement for the 2823
protection of the lives, health, and safety of employees, or when 2824
the same is occasioned by the willful act of the employer or any 2825
of ~~his~~ the employer's officers or agents, or by which it is agreed 2826
that the insurer shall pay any such damages. No license or 2827
authority to enter into any such agreements or issue any such 2828

policies of insurance shall be granted or issued by any public 2829
authority in this state. Any corporation organized or admitted 2830
under the laws of this state to transact liability insurance as 2831
defined in section 3929.01 of the Revised Code may by amendment of 2832
its articles of incorporation or by original articles of 2833
incorporation, provide therein for the authority and purpose to 2834
make insurance in states, territories, districts, and counties, 2835
other than the state of Ohio, and in the state of Ohio in respect 2836
of contracts permitted by division (B) of this section, 2837
indemnifying employers against loss or liability for payment of 2838
compensation to workers and employees and their dependents for 2839
death, injury, or occupational disease occasioned in the course of 2840
the employment and to insure and indemnify employers against loss, 2841
expense, and liability by risk of bodily injury or death by 2842
accident, disability, sickness, or disease suffered by workers and 2843
employees for which the employer may be liable or has assumed 2844
liability. 2845

(B) Notwithstanding division (A) of this section: 2846

(1) No contract because of that division is void which 2847
undertakes to indemnify a self-insuring employer against all or 2848
part of such employer's loss in excess of at least fifty thousand 2849
dollars from any one disaster or event arising out of the 2850
employer's liability under this chapter, but no insurance 2851
corporation shall, directly or indirectly, represent an employer 2852
in the settlement, adjudication, determination, allowance, or 2853
payment of claims. The superintendent of insurance shall enforce 2854
this prohibition by such disciplinary orders directed against the 2855
offending insurance corporation as the superintendent of insurance 2856
deems appropriate in the circumstances and the administrator of 2857
workers' compensation shall enforce this prohibition by such 2858
disciplinary orders directed against the offending employer as the 2859
administrator deems appropriate in the circumstances, which orders 2860

may include revocation of the insurance corporation's right to 2861
enter into indemnity contracts and revocation of the employer's 2862
status as a self-insuring employer. 2863

(2) The administrator may enter into a contract of indemnity 2864
with any such employer upon such terms, payment of such premium, 2865
and for such amount and form of indemnity as the administrator 2866
determines and the administrator may procure reinsurance of the 2867
liability of the public and private funds under this chapter, or 2868
any part of the liability in respect of either or both of the 2869
funds, upon such terms and premiums or other payments from the 2870
fund or funds as the administrator deems prudent in the 2871
maintenance of a solvent fund or funds from year to year. When 2872
making the finding of fact which the administrator is required by 2873
section 4123.35 of the Revised Code to make with respect to the 2874
financial ability of an employer, no contract of indemnity, or the 2875
ability of the employer to procure such a contract, shall be 2876
considered as increasing the financial ability of the employer. 2877

(3) A health insurance contract, policy, or agreement that 2878
undertakes to provide coverage of medical services, examinations, 2879
recommendations and determinations, nursing and hospital services, 2880
medicine, or other similar benefits for an injury or occupational 2881
disease that may be covered under this chapter or Chapter 4121., 2882
4127., or 4131. of the Revised Code is not void provided that the 2883
contract, policy, or agreement includes a provision stating that 2884
coverage for that injury or occupational disease ceases once a 2885
final determination is made under section 4123.511 or 4123.512 of 2886
the Revised Code stating that the claim is compensable under this 2887
chapter or Chapter 4121., 4127., or 4131. of the Revised Code. 2888

(C) Nothing in this section shall prohibit an employee from 2889
using the employee's health insurance or directly paying for 2890
medical services, examinations, recommendations and 2891
determinations, nursing and hospital services, medicine, or other 2892

similar benefits for an injury the employee suffered or 2893
occupational disease the employee contracted. 2894

Sec. 4123.93. As used in sections 4123.93 and 4123.931 of the 2895
Revised Code: 2896

(A) "Claimant" means a person who is eligible to receive 2897
compensation, medical benefits, or death benefits under this 2898
chapter or Chapter 4121., 4127., or 4131. of the Revised Code. 2899

(B) "Statutory subrogee" means the administrator of workers' 2900
compensation, a self-insuring employer, or an employer that 2901
contracts for the direct payment of medical services pursuant to 2902
division ~~(I)~~(J) of section 4121.44 of the Revised Code. 2903

(C) "Third party" means an individual, private insurer, 2904
public or private entity, or public or private program that is or 2905
may be liable to make payments to a person without regard to any 2906
statutory duty contained in this chapter or Chapter 4121., 4127., 2907
or 4131. of the Revised Code. 2908

(D) "Subrogation interest" includes past, present, and 2909
estimated future payments of compensation, medical benefits, 2910
rehabilitation costs, or death benefits, and any other costs or 2911
expenses paid to or on behalf of the claimant by the statutory 2912
subrogee pursuant to this chapter or Chapter 4121., 4127., or 2913
4131. of the Revised Code. 2914

(E) "Net amount recovered" means the amount of any award, 2915
settlement, compromise, or recovery by a claimant against a third 2916
party, minus the attorney's fees, costs, or other expenses 2917
incurred by the claimant in securing the award, settlement, 2918
compromise, or recovery. "Net amount recovered" does not include 2919
any punitive damages that may be awarded by a judge or jury. 2920

(F) "Uncompensated damages" means the claimant's demonstrated 2921
or proven damages minus the statutory subrogee's subrogation 2922

interest. 2923

Section 2. That existing sections 126.30, 1751.55, 1751.60, 2924
3923.05, 3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 4121.01, 2925
4121.44, 4121.441, 4121.442, 4123.01, 4123.30, 4123.343, 4123.35, 2926
4123.511, 4123.512, 4123.82, and 4123.93 of the Revised Code are 2927
hereby repealed. 2928

Section 3. This act applies to all claims pursuant to 2929
Chapters 4121., 4123., 4127., and 4131. of the Revised Code 2930
arising on and after the effective date of this act. 2931

Section 4. This act applies to all individual or group 2932
policies for sickness and accident insurance entered into on or 2933
after the effective date of this act and all policies, contracts, 2934
or agreements entered into between a subscriber and a health 2935
insuring corporation on or after the effective date of this act. 2936